

Oklahoma Health Care Authority



Oklahomans Working For Oklahomans

Service Efforts and Accomplishments
SFY2011

July 2010—June 2011

Foreword

Since January 1995, the Oklahoma Health Care Authority (OHCA) has been the primary entity for the state charged with purchasing state and federally funded health care coverage for low income Oklahomans. OHCA must assure that purchased health care meets acceptable standards of care and ensure that citizens who rely on state-purchased health care are served in a comprehensive and positive manner. As part of that charge, OHCA remains committed to pursuing excellence in the delivery of necessary services coupled with the highest quality of care for Oklahoma's citizens.



This report covers state fiscal year (SFY) 2011 Service Efforts and Accomplishments (SEA) and describes key measures tracked by the agency to ensure agency efforts are consistent with the state mandated mission and the strategic goals and objectives set forth by the OHCA's Board of Directors. This report is intended to provide the reader with information needed to evaluate the agency's performance.

While pioneering OHCA's future direction, it is often beneficial to reflect on its history. In 1992, an interim task force report to the Governor showed Oklahoma's Medicaid operating costs had grown an average of 20 percent per year over a 10-year period. For that time period, fee-for-service reimbursement was being utilized statewide. Oklahoma's leadership was committed to looking for sustainable, cost-effective, containment measures while considering statewide access for its members. These factors resulted in the formation of citizen committees tasked with examining innovative ways of restructuring the existing Medicaid program to meet the objectives noted above.

Recommendations received from the committees suggested a fundamental change from the traditional fee-for-service Medicaid program to the adoption of a Medicaid managed care system focusing on primary care, prevention, and increased access. Part of the committees' studies included the proven effectiveness other states had experienced when managed care programs were implemented. According to a report released in 2009 by the Center for Health Care Strategies, Inc., there were 26 other states that had some form of Medicaid managed care in 1992.

The Oklahoma Health Care Authority was established by the Legislature in 1993 to focus on prevention and primary care while reigning in spiraling health care costs and placing an emphasis on improved access to care. The newly formed entity, OHCA, was mandated to complete statewide conversion to a managed care



delivery system from the previous fee-for-service plan. At that time, OHCA chose to develop two distinct managed care delivery systems: the release of SoonerCare Plus (1995) and SoonerCare Choice (1996) was announced.

Because Oklahoma is extensively rural with some large urban cities, SoonerCare Plus was designed to allow for fully capitated services in the three largest cities in Oklahoma (Oklahoma City, Tulsa, and Lawton). SoonerCare Choice rolled out in rural areas as a partially capitated primary care case management program because the fully capitated approach would not have been feasible in rural areas.

In 1997, OHCA began administering enrollee satisfaction surveys in both the SoonerCare Plus and SoonerCare Choice programs. According to the 2009 Mathematica Policy Research, Inc. report, the findings demonstrated the SoonerCare Choice program performed about as well as the SoonerCare Plus program and rated higher on some of the elements measured.

A significant milestone in SoonerCare's history occurred in 2004 when OHCA achieved one statewide plan called SoonerCare Choice, providing primary care provider/case management to all of Oklahoma (PCP/CM). One of the health maintenance organizations (HMO) active in SoonerCare Plus decided to pull out of the program in late 2003. As a result of this withdrawal, an insufficient choice of health care providers would have resulted in some parts of the state. The OHCA board met and decided to end all of its HMO contracts as of December 31, 2003. OHCA took the necessary steps to transition the approximately 189,000 enrollees effective January 1, 2004. These individuals joined the approximately 160,000 other individuals already being served by the SoonerCare Choice program. There was much work to do to ensure a smooth transition, but OHCA staff maintained an unwavering commitment to the residents of Oklahoma. As a result, the changeover was successful with hundreds of new providers recruited, ensuring an adequate provider network, for the increased enrollment.

In existence since 2000, the Care Management Department was a 7-member team of nursing professionals helping to coordinate care for members with complex medical needs. With the plan conversion, almost 900 members were identified with complex or exceptional health care needs. As the number of members with care coordination needs grew substantially, Care Management's focus expanded to include: educational intervention, medical regimen reinforcement, and enhanced outreach to identified populations. These changes resulted in the division expanding from seven to 27 full-time employees. Responsibilities have continued to grow and today there are a total of 42 employees. The composition of the Care





Management Department is predominantly nursing professionals but now also includes behavioral health professionals, social service professionals, and support staff.

Another noteworthy event in 2004, which furthered OHCA's commitment to provide health care coverage for even more uninsured Oklahomans, was the legislative authority given to OHCA to develop the Insure Oklahoma program. Insure Oklahoma offers premium payment assistance to employees of qualified small businesses through the Employer Sponsored Insurance (ESI) program. Insure Oklahoma also administers the Individual Plan (IP), a state-sponsored health plan for those who would be eligible but do not have a participating employer in the ESI program. The ESI and IP programs were introduced in December 2005 and January 2007, respectively. Enrollment for the ESI program began in January 2006 while enrollment for the IP program began in January 2007.

In 2009, OHCA adopted a patient-centered medical home primary care delivery system endorsed by the Medical Advisory Committee and the Medical Advisory Taskforce. The model incorporates a managed care component with traditional fee-for-service and incentive payments. The intent was to build on the successes already achieved in SoonerCare Choice to establish an improved medical home for all SoonerCare Choice members. Primary Care Providers manage the specific health care needs of members, ensuring members receive the right care at the right time from the right provider. It was a seamless transition for members. More details can be found regarding Patient-Centered Medical Home on page 56.

SoonerCare enrollment has grown steadily over the years, from 458,558 in 1995 to 963,318 in 2011. The number of employees has also increased from 224.5 employees (inclusive of 22 part-time, contract, and seasonal positions) in 1995 to 485.5 (inclusive of 21 grant positions) for 2011.

There is much to share about SoonerCare, from its infancy to the program it has become, currently serving 25 percent of Oklahomans. While there is ample reason for pride in the SoonerCare program as it exists today, OHCA faces SFY2012 with the same level of commitment that prevailed in 1993 because it is a privilege to be Oklahomans working for Oklahomans.

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WELCOME TO OHCA'S 2011 SERVICE EFFORTS AND ACCOMPLISHMENTS REPORT

OHCA VISION

For Oklahomans to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Who might benefit from this report?

CITIZENS

Resource Providers

CUSTOMERS

Members and providers directly impacted by benefits and reimbursements

POLICY MAKERS

Officials responsible for allocating resources

OHCA'S BOARD OF DIRECTORS & MANAGEMENT

Leadership tracking our progress in meeting goals

RESEARCHERS / OTHER HEALTH CARE ORGANIZATIONS / FEDERAL PARTNERS

Entities comparing performance to benchmarks, targets, and other participants in medical care access

done (outputs), and the success in meeting objectives (outcomes). Resources expended will be compared to those outcomes and outputs (efficiencies). Estimates of future performance, future targets, and comparative benchmarks have also been included. In addition to OHCA,

Welcome to OHCA's 2011 Service Efforts and Accomplishment Report. OHCA has the mission of ensuring that low income individuals have access to medical care. OHCA's SoonerCare programs, including Insure Oklahoma, are critical in providing medical care to Oklahomans. The performance and administration of these programs must be examined and evaluated.

Stakeholders must have access to understandable and relevant performance data to make effective decisions as progress is made toward a healthier Oklahoma. This report describes key measures tracked by the agency to ensure OHCA's efforts are consistent with its state mandated mission and the strategic goals and objectives set forth by OHCA's Board of Directors.

OHCA hopes to equip the reader with information needed to assess its performance and ultimately play a strategic role in improving Oklahomans' health.

Content. This report provides performance information on 100 percent of the agency's operations. It covers three fiscal periods, State Fiscal Year (SFY) 2009, 2010, and 2011. Oklahoma's fiscal period runs from July through June. Additional performance data dating back as far as SFY2006 can be found in the tables located at the end of this report.

The key performance measures reported are intended to provide data about the resources OHCA has been allocated (inputs), the work

other Oklahoma agencies accumulate administrative costs which are federally funded through Medicaid including the Oklahoma Department of Human Services (OKDHS) and the Office of Juvenile Affairs (OJA). Only OHCA's administrative performance is discussed in this report.

Layout. Three levels of data are provided so users can seek out detail based on their degree of interest. The report is structured to show how the agency has performed in each of six goal areas.

Performance Highlights - In summary, results from a few key indicators for each of the six agency goals are reported at the beginning of each section to provide a slice of information regarding the agency's performance.

Detailed Performance Measures - For in depth analysis, each agency goal is stated along with the objectives and performance measures related to it. Targets, estimates, and benchmarks are also reported. Narrative is included to provide context, explanatory information, and anticipated future events that may impact the goal area.

Tables - For quick review and trend analysis, the agency measures are reported by goal in a table format at the end of this report. Actual data is reported from SFY2006 through SFY2011. Budgeted data is reported for SFY2012 and estimated data is provided for SFY2013.

For additional information on the steps OHCA has taken to ensure the information in this report is reliable, consistent, and shaped by public feedback, see Supplemental Information beginning on page 96.



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OHCA Mission

TO PURCHASE STATE AND FEDERALLY FUNDED HEALTH CARE IN THE MOST EFFICIENT AND COMPREHENSIVE MANNER POSSIBLE AND TO STUDY AND RECOMMEND STRATEGIES FOR OPTIMIZING THE ACCESSIBILITY AND QUALITY OF HEALTH CARE.

Goal # 1: Eligibility

To provide and improve health care access to the underserved and vulnerable populations of Oklahoma.

- To reduce the number of Oklahomans without access to medical coverage.
- To partner with others to enroll qualifying children, parents and other adults into SoonerCare.

Goal # 2: Quality and Satisfaction

To protect and improve member health and satisfaction, as well as ensure quality with programs, services and care.

- To seek and evaluate member feedback on satisfaction with services received when accessing SoonerCare benefits.
- To partner with Oklahoma's long-term care facilities to strive for quality long-term care services.

Goal # 3: Member Personal Responsibility

To promote members' personal responsibilities for their health services utilization, behaviors, and outcomes.

- To strive for SoonerCare children to receive necessary preventive care through Child Health / EPSDT services.
- To partner with other child serving organizations in the state to strive for Oklahoma's children to meet the federal immunization goal of 80 percent compliance.
- To increase ambulatory/preventive care use by adults.
- To decrease emergency room utilization by increased use of ambulatory care services.
- To educate members on the use of pharmacy services and monitor their behavior through the Lock-In program.
- To increase the number of pregnant women seeking medical care before delivery.

Goal # 4: Member Benefits

To ensure that programs and services respond to the needs of members by providing necessary medical benefits to our members.

- To ensure that SoonerCare Choice members receive coordinated health care services through a medical home.
- To maintain a provider network that can adequately meet the needs of members.
- To provide necessary benefits as indicated by the number of member appeals whose benefit complaints elevate to the appeals process.

Goal # 5: Responsible Financing / Purchasing

To purchase the best value health care for members by paying appropriate rates and exploring all available valid options for program financing to ensure access to medical services by our members.

- To reimburse providers, when applicable Medicare rates are available, at 100 percent of Medicare rates.
- To reimburse hospital providers a reasonable percentage of costs.
- To reimburse long-term care facilities a reasonable percentage of costs.
- To reimburse eligible professionals for participation in the Electronic Health Records (EHR) Incentive Program.
- To reimburse hospitals for participation in the Electronic Health Records (EHR) Incentive Program.

Goal # 6: Administration

To foster excellence in the design and administration of the SoonerCare program.

- To consistently perform administrative responsibilities within funding budgeted.
- To strive to accurately project the future costs of providing health care to Oklahomans.
- To strive to accurately project the future costs of providing Insure Oklahoma to Oklahomans.
- To pay SoonerCare claims within an accuracy rate of at least 97 percent, considering policy and systems issues and member eligibility.
- To maintain and/or increase program and payment integrity efforts which may result in recoveries.
- To actively pursue all third party liability payors, rebates and fees and recover or collect funds due to the SoonerCare and federal Medicare program.
- To train and educate SoonerCare providers, both on an “as-needed” and a proactive basis, through group and/or individual training and other communication.
- To ensure members and providers have access to assistance through member and provider services.



Goal # 1: Eligibility

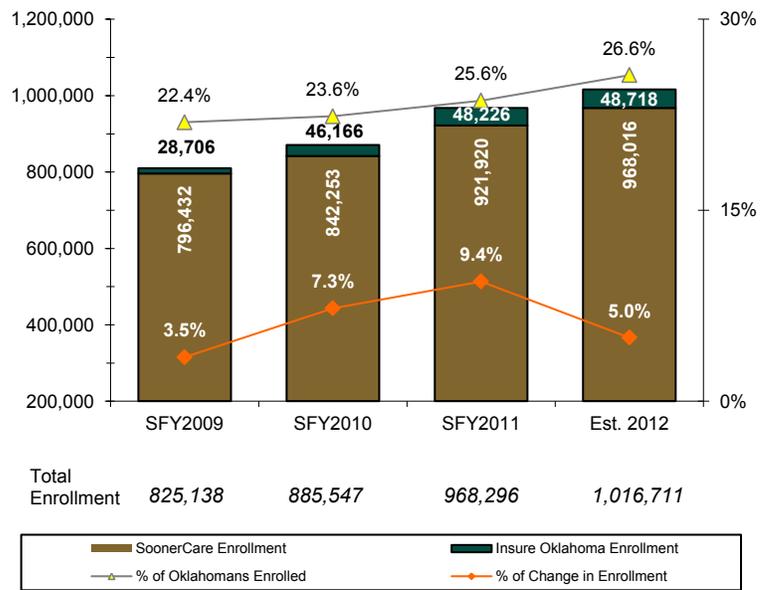
TO PROVIDE AND IMPROVE HEALTH CARE ACCESS TO THE UNDERSERVED AND VULNERABLE POPULATIONS OF OKLAHOMA.

Performance Highlights

The Performance Highlights provide a concise overview of the agency's progress towards achieving this goal. Performance Measures are provided in this section and include descriptive information as to what a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

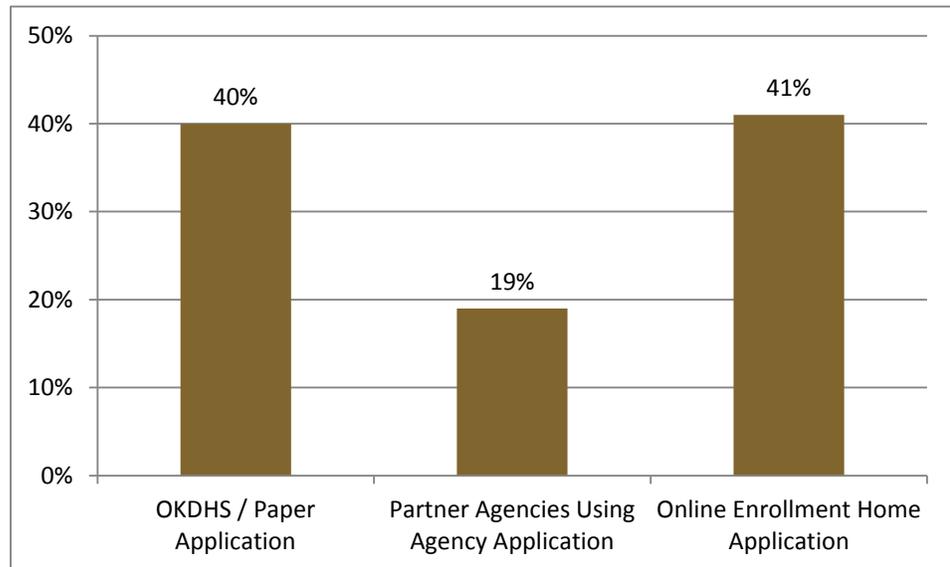
Figure 1

OHCA Programs Unduplicated Enrollment
Actual SFY2009 - 2011 / Est 2012



Source: OHCA MMIS, US Census Bureau

Online Enrollment Applications by Source (Sept 2010 to June 2011)



Source: OHCA Information Services Division

Figure 2



Goal # 1: Eligibility

TO PROVIDE AND IMPROVE HEALTH CARE ACCESS TO THE UNDERSERVED AND VULNERABLE POPULATIONS OF OKLAHOMA.

Oklahoma's Uninsured

The Oklahoma Health Care Authority (OHCA) plays a vital role in providing for the healthcare needs of Oklahomans. As of June 30, 2011, over 25 percent of Oklahomans received health insurance or another form of medical benefit from OHCA.

A lack of health insurance limits Oklahomans' access to needed medical care. The barriers the uninsured face in getting the care they need means they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact can also be severe. Uninsured families may struggle financially to meet basic needs, and medical bills, even for minor problems, can quickly lead to medical debt.

With over 624,000 Oklahomans uninsured in 2010, according to U.S. Census Bureau estimates, 17 percent of the state's population lacks basic coverage versus the national average of 16.3 percent.

When the uninsured seek care and cannot pay for it, the cost of their care is shifted to the state, providers, and consumers, thereby creating a "hidden tax" on medical services. Reducing the rate of uninsured Oklahomans would result in a substantial reduction in the cost of uncompensated care.

Oklahoma's uninsured rate decreased from 17.9 percent to 17.0 percent between 2005 and 2010.

Source: US Census Bureau, www.census.gov

UNINSURED IN OKLAHOMA BY AGE

	2005	2010
< 19	11.0%	12.2%
19-64	24.5%	23.1%
65+	1.0%	0.2%
Total	17.9%	17.0%

Source: State Health Access Data Assistance Center, www.shadac.org & OHCA Uninsured Fast Facts

Figure 3

According to the Kaiser Commission on Medicaid and the Uninsured, in 2009, 50 million people in the U.S. under age 65 lacked health insurance. Most of these individuals came from working families with low incomes. Adults were more likely to be uninsured than children because of children's access to programs like SoonerCare. The most common reasons given by the uninsured for not having health insurance are the high cost of purchasing an insurance plan and the lack of access to employer-sponsored coverage. The magnitude of these problems is expected to increase with the ongoing economic crisis, placing ever greater importance on OHCA's efforts to create avenues of access to health care.

Federal law provides the state with guidelines as to whom OHCA may cover under SoonerCare, providing Medicaid funding only for qualifying, low-income children, pregnant women and the aged, blind, or disabled. According to the Department of Health and Human Services (HHS), parents of children enrolled in SoonerCare may qualify for benefits if their income is 30 percent or below the federal poverty level (\$6,996 for a family of four based on 2010 FPL).

Accessibility to medical services is paramount to the overall health of Oklahomans. Oklahoma continues to make progress in reducing the number of uninsured citizens through innovative initiatives and improvements to existing programs. OHCA strives to implement methods to ensure those who are uninsured and eligible have access to public insurance. In SFY2011, OHCA implemented the Online Enrollment program in the first quarter. OHCA also began trying to increase enrollment of qualifying children with SoonerEnroll and improved the enrollment process for newborns with electronic automatic newborn enrollment (eNBI.)

Insure Oklahoma

Insure Oklahoma, which helps small businesses and their qualified employees afford health insurance, has two plans designed to assist qualifying low income, working Oklahomans in acquiring health insurance coverage.

The Employer Sponsored Insurance (ESI) plan is the state's premium assistance program that aims to make private health insurance affordable for both the employer and the employee. Currently, employees and their spouses earning 200 percent or less of the federal poverty level (FPL) qualify for Insure Oklahoma if they work for a business with 99 or fewer employees.

Insure Oklahoma also has the Individual Plan (IP) that provides coverage to those who are self-employed, employed in small businesses that do not participate in the ESI plan, disabled in the Ticket-To-Work program, or unemployed individuals looking for work. The IP plan currently has over 13,000 members participating.

SoonerEnroll

Approximately 60,000 children in Oklahoma qualify for SoonerCare, but are not enrolled in the program. SoonerCare would provide these children access to many services including immunizations, dental, vision, and medical care. OHCA implemented SoonerEnroll, an innovative plan to create a statewide infrastructure for outreach and enrollment for uninsured but qualified children. The goal of SoonerEnroll is to empower non-profit, public, and private community resources to assist their own community members with accessing the SoonerCare program. With over 200 community partners and an increase in SoonerCare enrollment, SoonerEnroll is a successful model of a state agency and local communities working together to for a healthy Oklahoma.



eNBI

Under federal law, a newborn whose mother who is enrolled in Medicaid at the time she gives birth is deemed eligible for Medicaid until age 1 (when renewal becomes necessary). OHCA has implemented an online enrollment system (eNBI) that ensures that newborns' automatic eligibility translates into actual enrollment in SoonerCare as soon as they are born, without delay. Because of the innovation, newborns now gain SoonerCare coverage almost immediately and their mothers select a primary care provider (PCP) for them even before they are discharged, ensuring that they have a medical home when they leave the hospital. Automatic newborn enrollment is in effect in nearly all of Oklahoma's 80 hospitals. Its impact is large because more than 60% of all Oklahoma births are covered by SoonerCare.

Online Enrollment

The goal of Online Enrollment is to eliminate barriers that might prevent potential members from applying for an OHCA program. Online Enrollment also increases efficiency by streamlining the enrollment process. The heart of the program is a system that allows Oklahomans with internet access to apply any time, anywhere. A comprehensive electronic rules engine uniformly applies policy and the applicant receives a real-time eligibility decision when the application is submitted. Approved applicants select their Primary Care Provider at the time of application. The online system eliminates the reliance on traditional, restrictive business hours and the typical 20-30 day lag in processing eligibility.

Online Enrollment became operational in September 2010. Phase I of implementation includes the SoonerCare and SoonerPlan populations, as well as the State Mental Health and Substance Abuse services population. Plans are to expand to Insure Oklahoma, the Aged, Blind, and Disabled, Breast and Cervical Cancer, and TANF populations in the future.

Health Care in Oklahoma

The Patient Protection and Affordable Care Act (ACA) was enacted on March 23, 2010. The federal law contains numerous provisions affecting nearly every area of the health care industry. One provision of the law includes a significant Medicaid expansion beginning January 1, 2014. This expansion, coupled with many additional Medicaid program modifications will substantially change the way the program operates. In SFY 2011, OHCA began implementing portions of the law and planning for the major changes required by the Medicaid expansion.

The Medicaid expansion allows all Oklahomans at or below 133% of the Federal Poverty Level to qualify for SoonerCare in 2014. Children currently covered by CHIP between 100% and 133% of poverty would be transitioned to Medicaid coverage.



As part of the Medicaid expansion, the law provides full federal financing for those newly eligible for Medicaid during years 2014 through 2016; 95% FMAP for 2017; 94% FMAP for 2018; 93% FMAP for 2019 and 90% FMAP for 2020 and beyond. Financing for those who enroll in SoonerCare who were already eligible (woodwork members) will be federally funded at current FMAP rates.

In 2014, OHCA expects approximately 140,000 new members and 30,000 woodwork members (based on Congressional Budget Office Estimates) at a state cost of \$24 million. To meet the coming challenges of serving an expanded population eligible for SoonerCare and the associated costs, OHCA is taking several steps, including:

- Identifying the existing health care system capacity and areas needing improvement;
- Requesting additional full time employees to support operational efforts serving SoonerCare members;
- Determining the amount of state funds that will be required to continue to provide quality service;
- Modifying technological systems to accommodate enrollment and health plan management of new SoonerCare members; and
- Implementing early Program Integrity Requirements of the ACA such as payment suspension based on credible allegation of fraud, contracting with Recovery Audit Contractors, and contract termination of providers already terminated by Medicare or CHIP.



Get Connected

As a government agency, OHCA works hard at being transparent and offering as much information as possible.

Oklahomans can keep up with OHCA's latest marketing efforts and public information by following OHCA on Twitter, Facebook, or YouTube. Feel free to follow OHCA to keep up to date with the latest developments in SoonerCare and Insure Oklahoma.

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OBJECTIVE	TO REDUCE THE NUMBER OF OKLAHOMANS WITHOUT ACCESS TO MEDICAL COVERAGE.	
Outcome:	% Enrolled in SoonerCare & Insure Oklahoma <i>2011 Actual - 25.6%</i> <i>2012 Estimate - 26.6%</i>	
Output:	Unduplicated SoonerCare Enrollment <i>2011 Actual - 921,920</i> <i>2012 Estimate - 968,016</i>	
Output:	Unduplicated Insure Oklahoma Enrollment <i>2011 Actual - 48,226</i> <i>2012 Estimate - 48,718</i>	
Outcome:	% Change in Total Enrollment <i>2011 Actual - 9.3%</i> <i>2012 Estimate - 5.0%</i>	

What do these measures report?

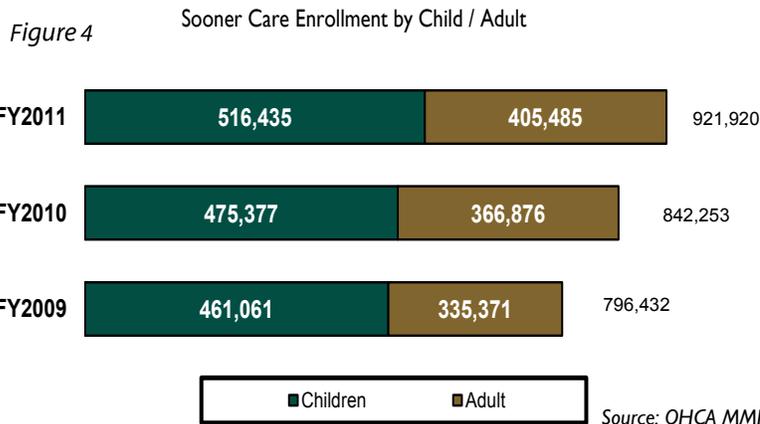
These measures report the unduplicated number and percent of Oklahomans enrolled in SoonerCare and Insure Oklahoma and the percentage change from year to year.

What do the latest results mean?

The steadily increasing number of Oklahomans receiving medical coverage through OHCA suggests the difficulty many are having in finding affordable health care insurance in the private market or through employers.

Due to the counter-cyclical nature between public health programs and economic conditions, both SoonerCare and Insure Oklahoma continue to experience steady growth in enrollment. As individuals lose jobs, or employers opt out of offering health insurance, the demand for OHCA services increase.

The unduplicated enrollment in SoonerCare and Insure Oklahoma reflect the number of Oklahomans who had access to medical services through OHCA’s programs. See the information beginning on page 18 to find out more about the demographics of SoonerCare and Insure Oklahoma populations.



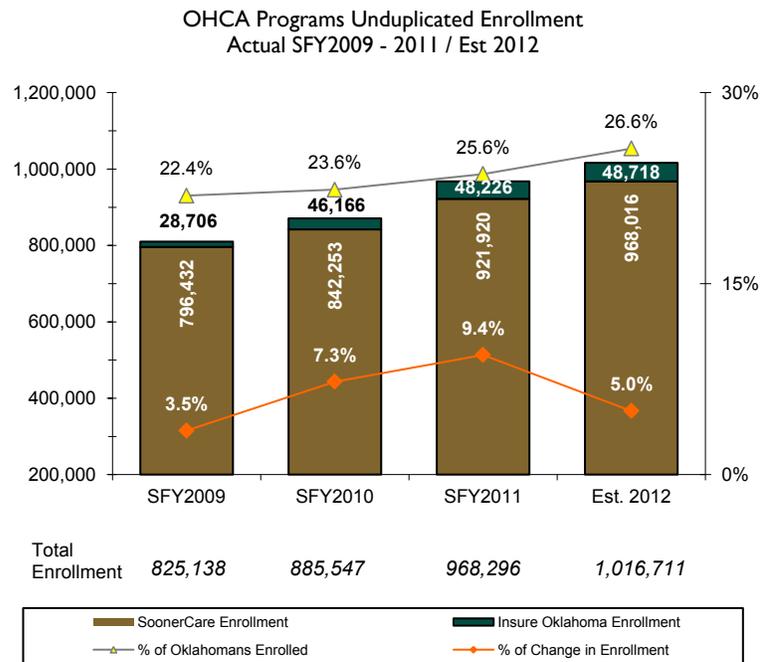
The Insure Oklahoma plans are limited by the amount of tobacco tax revenue allotted by the state. The current provision is expected to cover approximately 35,000 individuals. At current

**Insure Oklahoma enrollment numbers are not included in this chart. Enrollment information for the Insure Oklahoma program can be found on page 22.*

enrollment rates, it is anticipated that the Insure Oklahoma plans will reach that cap during SFY2012.

* Note: The enrollment number of 48,266 for Insure Oklahoma mentioned above includes all Oklahomans who were in the program at some point during the year. Many members enter the program then leave as their situation changes, such as when they acquire health insurance through an employer that is not enrolled in Insure Oklahoma. As of June 30, 2011, Insure Oklahoma enrollment totaled 32,600.

Figure 5



What is OHCA doing to affect these measures?

According to the Census Bureau’s 2010 Current Population Survey, more than 624,000 Oklahomans were uninsured in 2010. Of that number, 82.3 percent were adults over 18 years old. At this time, Federal Medicaid laws prevent SoonerCare from covering specific populations including childless adults and parents earning over 30 percent of the FPL.

The Insure Oklahoma (IO) program, funded by federal dollars matched to state tobacco tax funds, assists individuals, working people, and small businesses to close the gap created by Federal Medicaid enrollment limitations. Individuals with household income at or below 200 percent of the FPL may qualify for one of two plans.

The program maintained steady enrollment in SFY2011, ending the year at just over 32,000 members. Insure Oklahoma has two programs that assist Oklahomans in obtaining health care coverage.

The first program, known as Employer Sponsored Insurance (ESI), helps small businesses and their qualified employees afford health insurance by paying 60 percent or more of the employees and 85 percent or more of the spouses’ premiums. Qualified employer guidelines stayed the same for SFY 2011, allowing businesses with up to 99 employees to participate. By June 2011, 5,261 employers were approved for Insure Oklahoma, down from 5,496 in June 2010. By the end of SFY 2011, approximately 15,100 employees and about 3,100 of their spouses were receiving an average of \$278.10 per month in premium assistance through ESI.



Figure 6

Insure Oklahoma Enrollment at June 30, 2011			
Employer Sponsored Insurance:	SFY2009	SFY2010	SFY2011
Number of Businesses	4,752	5,496	5,276
Number of People Enrolled*	14,217	18,753	18,816
Percent Change in Enrollment	62%	32%	0%
Individual Plan			
Number of People Enrolled*	7,381	13,107	13,784
Percent Change in Enrollment	153%	78%	5%

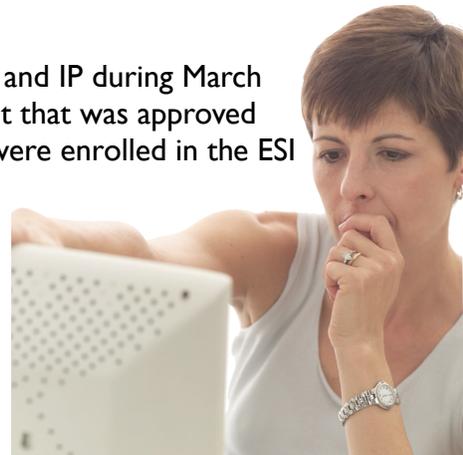
* These are not unduplicated. Numbers reflect status at a point in time - June 30, 2011.

Source: OHCA Fast Facts

The second program is the Individual Plan (IP), which provides assistance to individuals who are not qualified for the ESI program. During SFY 2011, these were individuals who worked for a small business with no more than 99 employees, were temporarily unemployed adults eligible for unemployment benefits, or disabled workers with in the Ticket to Work program. Over 13,200 workers and their spouses were receiving premium assistance through IP at the close of SFY2011.

Qualified full-time college students began enrolling in ESI and IP during March 2009. This expansion was allowed by a waiver amendment that was approved the previous year. At the end of SFY 2011, 114 students were enrolled in the ESI program and 351 were enrolled in the IP program.

In July of 2010, a state plan amendment allowed OHCA to enroll children of employees in families that earn between 186% and 200% of the poverty level. Enrollment began in early SFY 2011, and by the end of the year, 532 dependents were enrolled in the ESI or IP plan. In October 2010, a dental program was added for the children of enrollees.



The growth in the program has been essential to providing a larger portion of Oklahoma's population with access to health insurance and medical care. But with the growth in enrollment comes growth in costs. Insure Oklahoma was designed to expand until the costs equaled the tobacco tax revenue dedicated to the program, and is currently estimated to hit the funding cap at approximately 35,000 individuals, not including students and children. With enrollment increasing, Insure Oklahoma will likely approach its limit in the next few years. Other resources must be found in order for the program to cover more uninsured.

Additional information about Insure Oklahoma is available online at insureoklahoma.org.



OBJECTIVE | TO PARTNER WITH OTHERS TO ENROLL QUALIFYING CHILDREN, PARENTS, AND OTHER ADULTS INTO SOONERCARE.

Output: Unduplicated Number of Children Enrolled in SoonerCare
 Output: Unduplicated Number of Adults Enrolled in SoonerCare

What do these measures report?

These measures break out enrollment for adults and children. OHCA continues to follow the demographics of its membership by tracking enrollment through eligibility categories. This page displays the breakdown of individuals enrolled.

What do the latest results mean?

These measures indicate the demographic characteristics, nature, and scope of several OHCA populations. OHCA uses past and current enrollment when estimating future enrollment. These numbers are also used to formulate ideas for new programs or recommend changes to existing programs.

What is OHCA doing to affect these measures?

QUALIFYING FOR SOONERCARE

To qualify for health benefits through SoonerCare, individuals must meet specific criteria. Besides income, other factors determine the category of membership and define the benefits for which they qualify.

CHIP. The federal Children’s Health Insurance Program (CHIP) allows states to increase the federal poverty level (FPL) limit for children. SoonerCare covers children with family income up to 185 percent of the FPL (federal Medicaid minimum is 133 percent). The state receives an enhanced federal matching rate for children above 133 percent.

ABD. Aged, blind or disabled (ABD) members make up a small percentage of SoonerCare, but account for a large portion of expenditures (53%).

TEFRA. The Tax Equity and Fiscal Responsibility Act (TEFRA) population are children under the age of 19 years old with physical or mental disabilities that meet

Qualifying Category*	SFY2009	SFY2010	SFY2011
CHIP	114,804	116,968	117,229
ABD**	167,537	200,457	197,021
TEFRA	308	385	429
Oklahoma Cares	6,834	6,522	5,141
SoonerPlan	31,755	39,479	58,693
Dual Eligibles	112,999	115,693	119,797

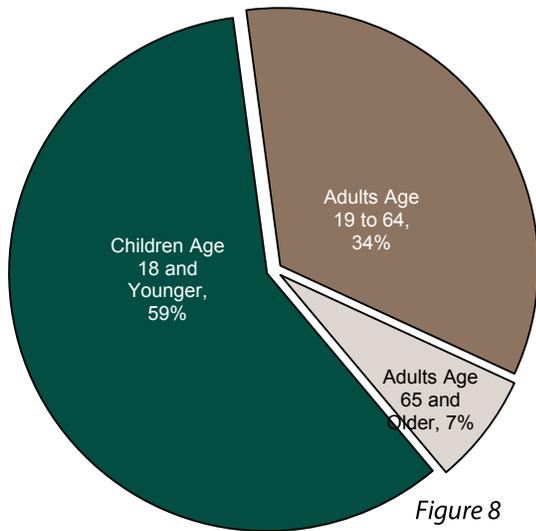
Source: OHCA MMIS

Figure 7

* Members may be counted in more than one category, i.e. a child counted in TEFRA may also be counted in the ABD population.

**ABD calculation method was changed to reflect all enrolled members who had ever been categorized as an ABD member versus reporting the last category of record. Previously reported numbers were 2008 - 143,895 and 2009 - 146,791. The 2010 numbers were not available at the time of this report.

Age of SoonerCare Enrollees SFY2011



Source: SFY2011 Annual Report

Figure 8

the criteria to receive institutional care. TEFRA allows a child to qualify on his/her own income rather than the family, whose income is above SoonerCare limits. Children qualifying through TEFRA are able to remain in the home and receive medical benefits. TEFRA is a subset of the ABD population.

Oklahoma Cares. This category is made up of women under the age of 65 who have been diagnosed with breast or cervical cancer, have a precancerous condition, or require further testing due to abnormal results from previous tests. They have access to all SoonerCare benefits until they no longer need treatment for breast or cervical cancer or they no longer meet the qualifying criteria.

SoonerPlan. SoonerPlan is a family planning, limited benefits package available to men and women ages 19 and older with income at or below 185% of FPL.

Other Demographics. OHCA releases an Annual Report that includes information about its programs, members, and administration. The surrounding charts are from the SFY2011 Annual Report and provide a look at some of the characteristics of the members served by OHCA. The Annual Report can be accessed on OHCA’s website at www.okhca.org/research/Reports.

The agency also releases monthly Fast Facts on several key areas including enrollment, programs, specific member groups and the uninsured. The Fast Facts are available on the OHCA website at www.okhca.org/research/Statistics and Data.

OHCA is constantly looking to improve the enrollment process for members. eNBI and SoonerEnroll are two programs that are currently helping members.

Figure 9

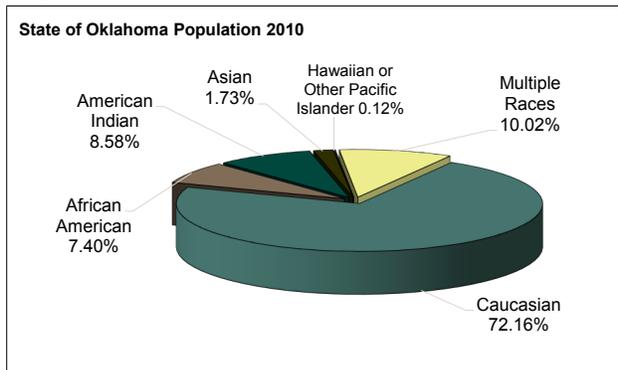
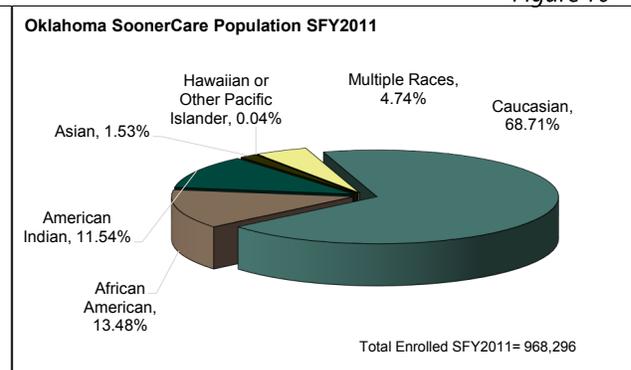


Figure 10

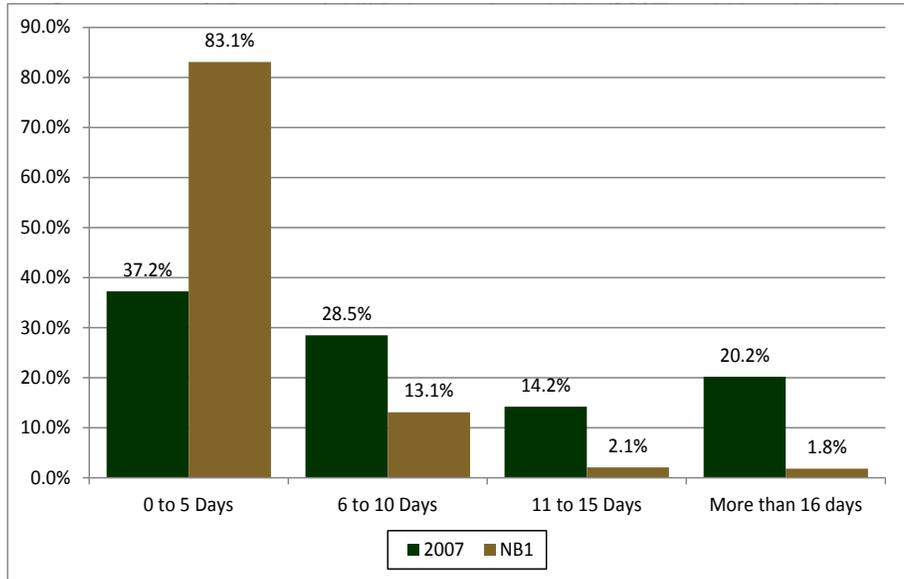


Total Estimated Population 2010 - 3,751,351 (Hispanic or Latino Ethnicity = 332,007)
 Oklahoma totals based on U.S. Census Bureau, Oklahoma State Data Center 2010 Population - single race reported alone counts. Census collects Other Race, not listed in the other 5 major categories.

Total Enrolled in SoonerCare and/or Insure Oklahoma - 968,296 (Hispanic or Latino Ethnicity = 137,241) The multiple race group has two or more races reported. Race is self-reported by members at the time of enrollment.

eNBI Enrollment

Under federal law, a newborn whose mother who is enrolled in Medicaid at the time she gives birth is deemed eligible for Medicaid until age 1 (when renewal becomes necessary). OHCA has initiated electronic newborn enrollment to expedite newborns' enrollment in SoonerCare, promptly connect them with care, and enable hospitals and primary care providers to bill right away for care that they provide to SoonerCare newborns.

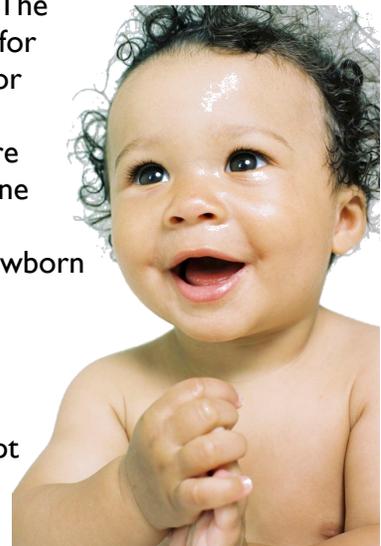


Source: OHCA Information Services Division Figure 11

Before electronic newborn enrollment, Oklahoma enrolled newborns in SoonerCare with a paper form known as the Newborn-1 (or NB-1). This complex process involved hospital staff, two state agencies and took between 14 and 21 days to complete the process.

Now, when a baby is born in an Oklahoma hospital, a hospital enrollment coordinator searches the SoonerCare system to verify the mother's SoonerCare eligibility. The enrollment coordinator calls the mother while she is still in the hospital and asks her to choose a PCP for her newborn from an online directory.

The system immediately links the newborn's case to the mother's and generates a SoonerCare ID number for the baby. This link enables OHCA to conduct outreach to the mother for future well baby appointments and other follow-ups. The system generates a temporary card for the newborn, and copies for both the hospital and the PCP so that they can bill SoonerCare for services right away. Providers can also check the SoonerCare website to verify that a baby is covered. A permanent SoonerCare card for the newborn is mailed home within a few days. This online enrollment process takes five minutes, compared to 60 minutes under the paper-based process, and the average time to add a newborn to the SoonerCare system is down to 3.5 days.



By June 2011, Oklahoma had enrolled over 74,000 newborns in SoonerCare electronically (nearly 2,000 babies are enrolled electronically every month). The process ensures not only prompt enrollment of newborns, but also consistent interpretation of eligibility rules previously implemented inconsistently across



counties and caseworkers. With their SoonerCare coverage and PCP in place before they leave the hospital, Oklahoma's newborns start out with access to the care they need firmly established.

In addition to its obvious benefits for newborns, automatic newborn enrollment has also yielded benefits for hospitals, PCPs, and the state. The system improves support for provider participation in SoonerCare by enabling PCPs to verify a newborn's coverage and medical home selection in real-time allowing them to be paid promptly.

SoonerEnroll

In Fall 2009, with the help of a CHIPRA grant, OHCA launched SoonerEnroll, an initiative focused on decreasing the number of Oklahoma's children who are uninsured but qualify for SoonerCare, Oklahoma's Medicaid/CHIP program.

The goals of the initiative are as follows: 1) enroll children eligible for SoonerCare but not enrolled; and, 2) improve the rate of successful and timely recertification of children. OHCA is committed to providing quality health care for all of Oklahoma's children, and SoonerEnroll is instrumental in reaching that vision.

SoonerEnroll employs a number of state and community-level strategies to increase enrollment and retention of children in SoonerCare. Four regional coordinators and a number of temporary community outreach associates provide training and technical assistance to community partners and work closely with them in the development, implementation and evaluation of plans designed to meet the needs of local communities.

An important outcome of SoonerEnroll is the creation of a sustainable statewide infrastructure for implementation of outreach and enrollment efforts beyond the scope of the grant. Currently, SoonerEnroll has more than 600 partners around the state. This collaborative network provides an effective means of outreach at the local level.

State-level strategies already identified include establishment of a sustainable infrastructure for outreach efforts via strengthening of existing linkages and creation of new linkages among statewide associations and local community partners; capacity-building among state and community partners via

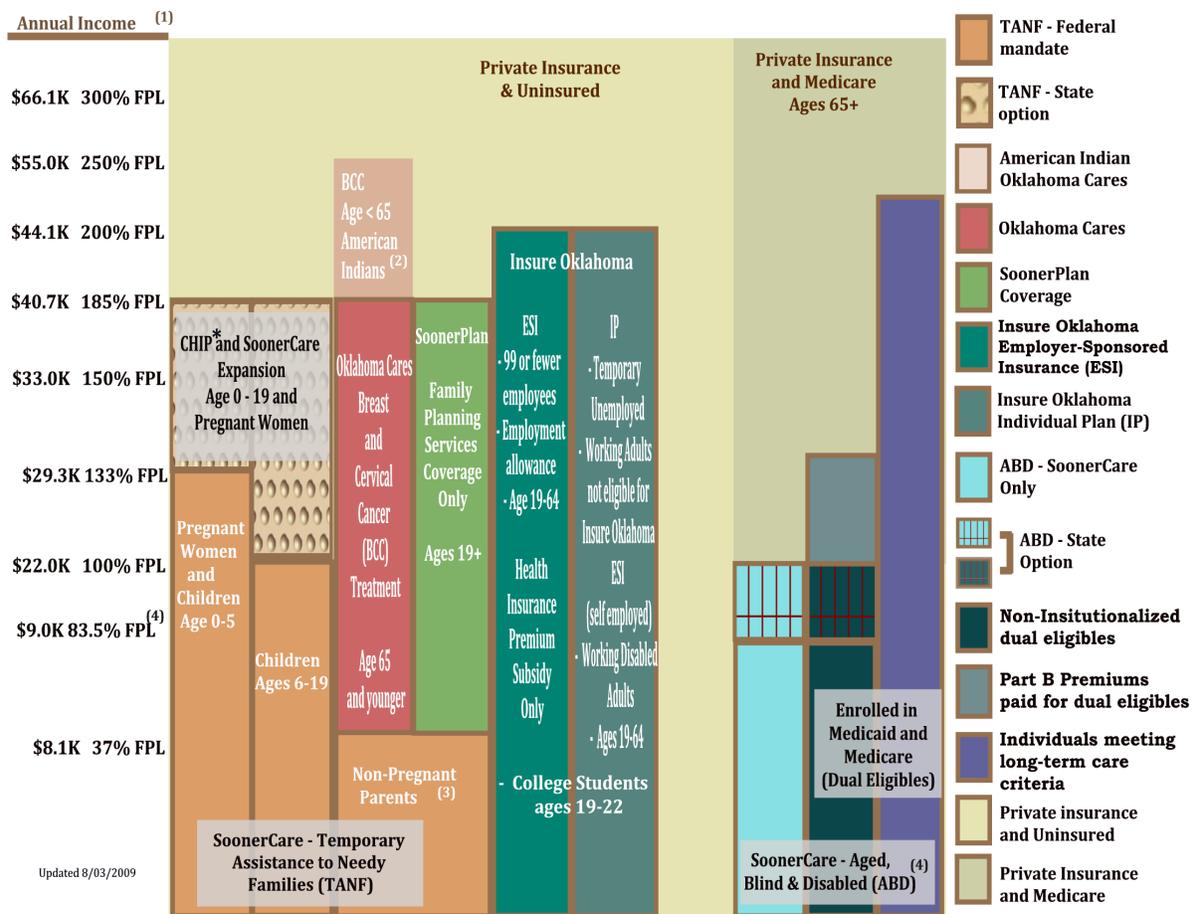


training and technical assistance (e.g., tool kits) to enhance their ability to effectively and efficiently implement outreach, enrollment and retention strategies; assistance with online enrollment training for community partners; and, a telephonic re-enrollment pilot.

At the community level, partners assist in a number of ways, including assistance with coordination and administration of focus groups and surveys to identify challenges and barriers to enrollment; identification of uninsured children; participation in a collaborative process for developing, implementing and evaluating local action plans designed to enroll eligible children; and, marketing and community education.

In an effort to reduce the gap in coverage for qualified children, two re-enrollment associates make outbound calls to recertify children whose membership expired sixty days or more prior to the call date. Over the past several months of SFY2011, associates have averaged more than 3,000 children recertified for SoonerCare. For the quarter ending June 30, 2011, more than 8,000 children were recertified using the telephonic process alone. Feedback from parents and guardians utilizing this recertification method has been very positive.

2010 FEDERAL POVERTY GUIDELINES (FPL) AND COVERAGE



(1) 2009 Federal Poverty Guidelines. U.S. Department of Health and Human Services. Based on a family of four.

(2) Oklahoma Cares qualifications are up to 250% FPL for American Indians only.

(3) Approximately 37 percent of federal poverty level (FPL) based on single parent family.

(4) Income shown is for single individuals.

* CHIP is the Children's Health Insurance Program.

IMPORTANT - the above information is a very basic overview of the federal poverty level and coverage groups. Each group has varying qualifying criteria. Specific details can be found at www.okhca.org under Individuals.

OBJECTIVE TO PARTNER WITH OTHERS TO ENROLL QUALIFYING CHILDREN, PARENTS, AND OTHER ADULTS INTO SOONERCARE.

Input: % of Online Enrollment Applications by Source

What does this measure report?

This measure reports the percent of Oklahomans applying for SoonerCare through the Online Enrollment application.

What do the latest results mean?

After implementation, Online Enrollment immediately became the preferred method of applying for SoonerCare. With the program still in the early stages, OHCA is constantly developing measures to track the success of the program. In future years, OHCA will present historical data for the Online Enrollment program to enable readers to measure its effectiveness.

What is OHCA doing to affect this measure?

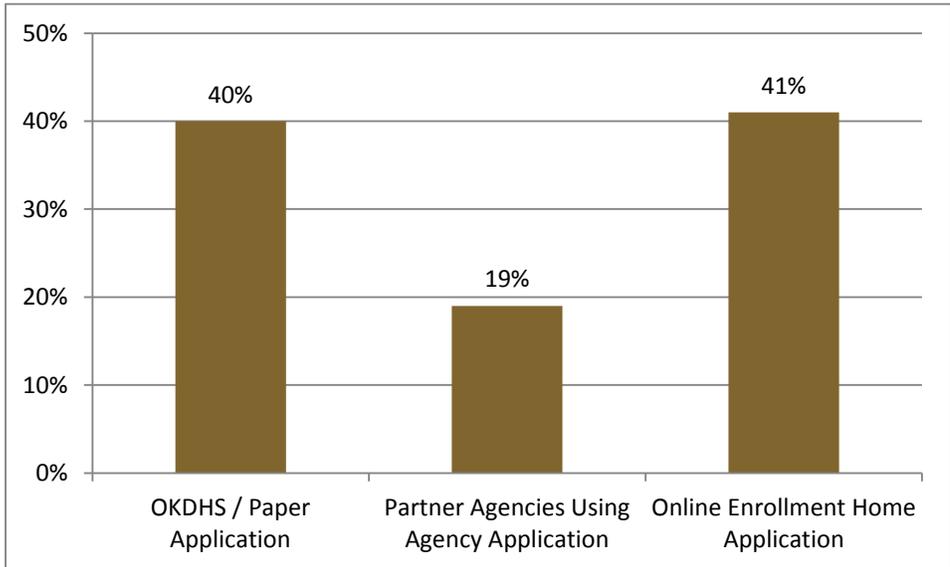
In September 2010, OHCA implemented Online Enrollment. This implementation included the transfer of responsibility to determine eligibility and enroll more than 500,000 Oklahomans from the Oklahoma Department of Human Services (OKDHS) to OHCA. Prior to Online Enrollment, applicants were required to visit an OKDHS County office in person, or fill out a paper application and mail it to OKDHS.

In either case, the eligibility determination and ensuing enrollment could take up to a month to complete.

Online enrollment provides many enrollment possibilities for SoonerCare applicants. An online home



Online Enrollment Applications by Source (Sept 2010 to June 2011)



Source: OHCA Information Services Division

Figure 12

application can be submitted from any computer that has internet access. An agency application is used by agency partners, including OKDHS, the Oklahoma State Department of Health (OSDH), Indian Health

Online Enrollment Applications			
By Disposition		By Type	
Approved	355,435	New Applications	298,101
Denied	66,299	Recertification	123,633
Approval Rate	84.27%	Percent of New Applications	70.68%

Source: OHCA Information Services Division

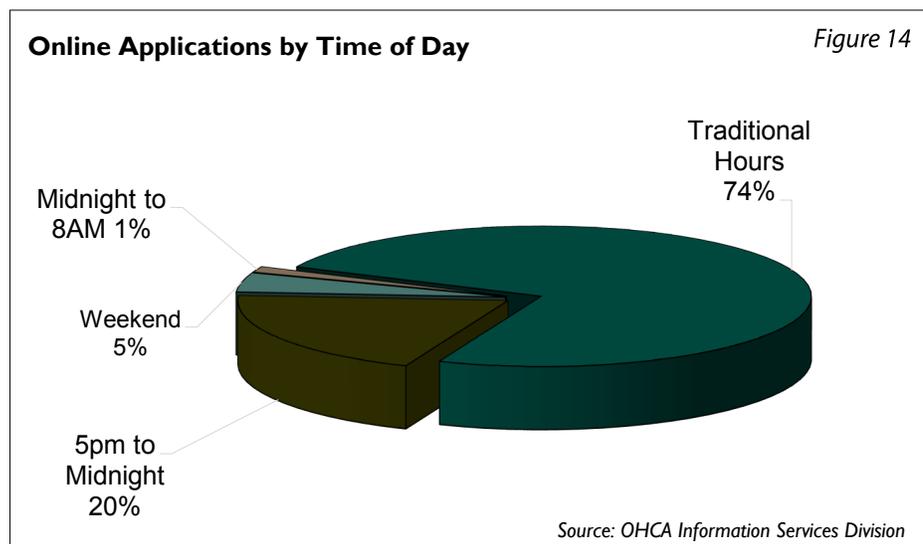
Figure 13

Services, and several Tribes to assist members in the enrollment process. With online enrollment, a member can receive eligibility results within minutes instead of weeks. The paper application still exists, but it is now received at OHCA, where it is scanned, data entered, and processed for enrollment in a matter of days. With the option to receive an immediate response, the number of paper applications dropped sharply soon after implementation of online enrollment.

The online enrollment process uses an electronic rules engine to determine eligibility for programs including SoonerCare, SoonerPlan, as well as state sponsored behavioral health services. This process ensures that policy is applied uniformly for all Oklahomans. Verifications of data are accomplished through data exchanges with the Social Security Administration, the Oklahoma Employment Security Commission, and OSDH, as well as other state and federal agencies. When the applicant clicks the “submit” button, and is qualified to receive benefits, they receive a real-time SoonerCare enrollment. The member is provided a SoonerCare identification number, is aligned with a Medical Home, and can seek services immediately.

As of June 2011, with less than one year in operation, OHCA had processed 384,487 applications, and enrolled or re-enrolled 564,409 members through online enrollment. Approximately 40% percent of the total applications received originated at OKDHS or were paper applications, 19 percent were from other partner agencies using the agency application, and 41 percent came through use of the home application.

This innovation is considered one of the most advanced State enrollment services in the nation, and at the 2011 Quality Oklahoma Team Day Awards at the state capitol, they received a Governor’s Commendation of Excellence as well as the Motivating the Masses Award.



Source: OHCA Information Services Division

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Goal # 2: Satisfaction and Quality

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY WITH PROGRAM SERVICES AND CARE.

Performance Highlights

The Performance Highlights provide a concise overview of the agency’s progress towards achieving this goal. Performance Measures are provided in this section and include descriptive information as to what a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

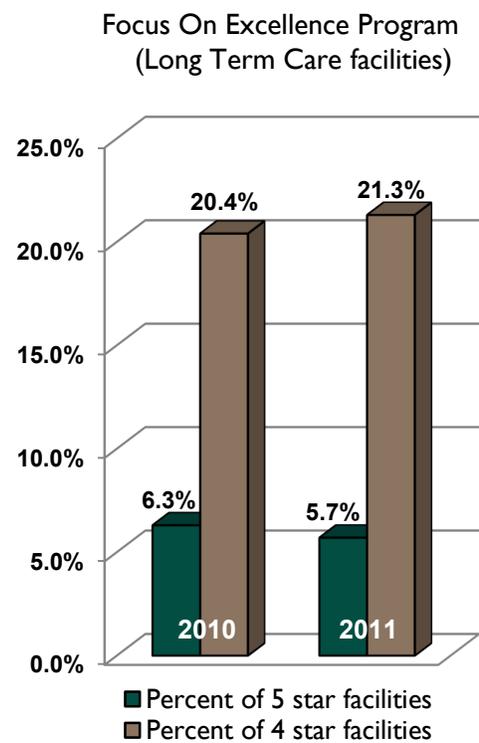
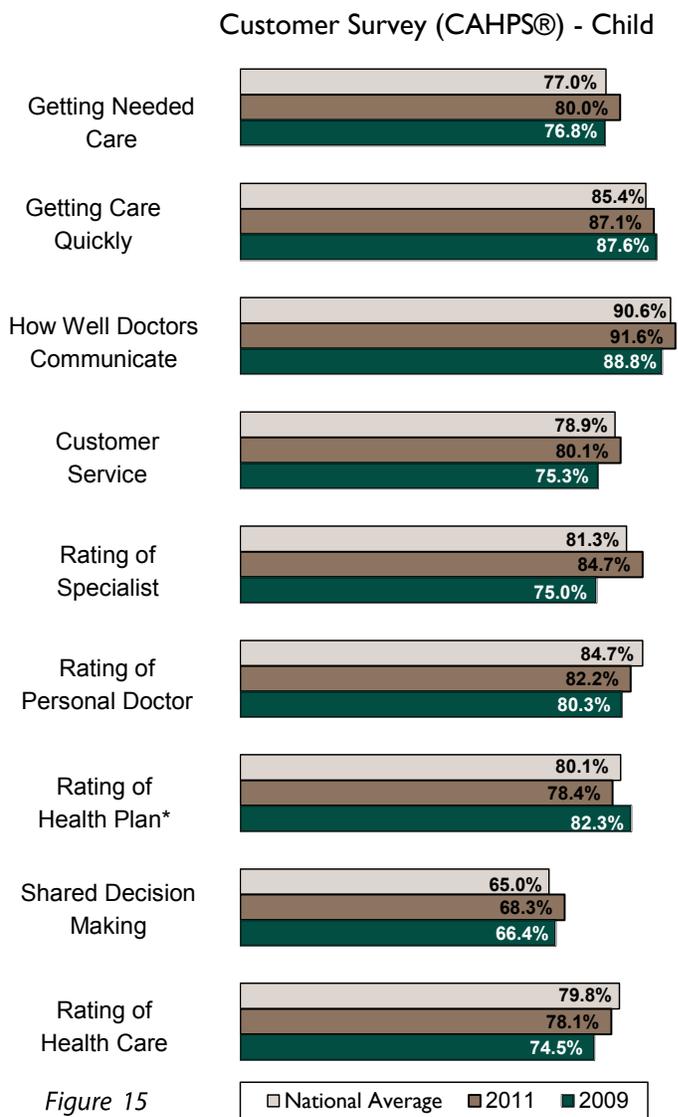


Figure 16

*SoonerCare is the program being rated by this measure.



Goal # 2: Satisfaction and Quality

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY WITH PROGRAM SERVICES AND CARE.

SoonerCare encompasses a number of benefits and services joined by federal and state legislation and administrative and procedural requirements to ensure medical care for low income individuals meets qualifying criteria for available programs. SoonerCare also includes several waiver programs. The agency makes every effort to ensure that members are able to access the benefits they are qualified to receive in a timely manner and with a high degree of satisfaction. SoonerCare and Insure Oklahoma programs serve members with diverse health conditions and needs. Each member bases individual satisfaction on different factors. Quantifying quality and levels of satisfaction for such an array of members and benefits is a challenge. One of the ways OHCA gathers information about members' health care experiences is through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Adding to this challenge is the constantly changing health care industry, new innovations in delivery of care, and operating changes. OHCA is continuously adapting to provide the services needed by our members. For purposes of monitoring quality and satisfaction, OHCA conducts on-site reviews, performs research studies, and contracts for independent annual surveys of our members. OHCA collaborates with stakeholders to explore new opportunities for improving our services.

The Quality Assurance and Quality Improvement (QA/QI) unit of OHCA leads agency quality and satisfaction efforts. Below are some of the activities OHCA is engaged in to ensure quality and to report results.

Patient Centered Medical Home (PCMH) Reviews

The Patient Centered Medical Home model of health care delivery was implemented in 2009 and is discussed in more detail on page 56. The QA/QI unit spent much of 2009 educating providers about the medical home concept as well as conveying requirements of the model. No reviews were conducted. Approximately 740 Medical Home contracted providers were educated during that year. The QA/QI unit began reviewing Medical Home practices in 2010. The review teams were comprised of compliance analysts and registered nurses with





clinical experience. This allowed the team to review administrative measures and educate office staff as well as complete medical records reviews.

The QA/QI unit uses a review tool that combines contract requirements with medical home processes and medical quality indicators. Administrative and medical records reviews are the two major elements examined. Because providers complete and submit a self-evaluation declaration regarding the tier they have chosen, the review is based on that selected tier. Tier

1, considered entry level, includes requirements for all Medical Home providers, while tiers 2 and 3 include additional requirements for each level.

The possible results of a review are: 1) fully compliant and returned to the review pool for the next cycle; 2) non-compliant and a corrective action plan must be submitted and approved within 45 days; and/or 3) a tier decrease. When a medical records corrective action plan is required, the provider will receive a request for medical records within a 6 to 12 month period; a member of the QA/QI staff reviews information supplied to ensure that the corrective action plan has been successfully implemented.

Quality Research

The QA/QI unit conducts member satisfaction surveys and participates in several studies. The studies are completed to support continuous quality assurance and improvement efforts. Recent studies were delayed as OHCA transitioned its new Quality Improvement Organization (QIO), Telligen, into place effective July 2011. Telligen, formerly named Iowa Foundation for Medical Care, has many years of experience in improving the quality of health care for consumers and providers.

SFY2012 promises to be a productive time with as many as seven studies planned with the new vendor, Telligen, coupled with ongoing member satisfaction studies. The results will be included in next year's publication.

Proposed studies include: 1) Comprehensive Diabetes Care; 2) Behavioral Health Rehabilitation Services; 3) Evaluation of Emergency Room Services; 4) Patient Centered Medical Home; 5) Antipsychotic Use Among Children in the SoonerCare Population; and 6) Weight Assessment. A possible seventh study is still under development. Adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) satisfaction surveys will be completed as well as the Child Experience of Care and Health Outcomes surveys (ECHO®). Both of these surveys are used to determine member satisfaction and will be discussed in greater detail within this section.



Reports prepared for previous years' quality activities are maintained on OHCA's website at www.okhca.org/research/studies.

CAHPS®

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys have been developed by the Agency for Healthcare Research and Quality (AHRQ) in coordination with public and private research organizations known as the CAHPS® Consortium. The purpose of the CAHPS® survey is to evaluate patients' satisfaction with their health care experiences. Beginning in SFY2011, the CAHPS® survey for children will be conducted annually because of Children's Health Insurance Program (CHIP) reporting requirements. The adult survey will be completed every two years. Results of the CAHPS® child survey are provided on page 32.

According to the AHRQ website, the CAHPS® survey is a standardized questionnaire that allows a comparison of results over time. AHRQ considers the consumer/patient to be the best source of information. Significant emphasis has been placed on issues relevant to both consumers/patients. For example, recent revisions to the 4.0 survey helped meet one of the goals of providing better understanding among diverse populations by the rewording of questions.

ECHO®

The Experience of Care and Health Outcomes (ECHO®) surveys were developed to gauge consumer satisfaction with the behavioral health treatment that they received. The adult ECHO® survey was administered to a random sample of SoonerCare adults that received behavioral health services during the past year. A report, comprised of responses received to questions ranging from how quickly treatment was available to how well clinicians communicated, provides OHCA with valuable member feedback. The results are compared to responses given in previous years (2007 and 2009) to determine if the satisfaction levels have changed in the various measured categories. Overall, the trend data shows that satisfaction continues to rise. Of the three composites reviewed in the report, each showed significant improvement when compared with 2009 trend data. This report is available on OHCA's website at www.okhca.org/research/studies/satisfaction_surveys.

MINDING OUR P'S & Q'S

OHCA reports ongoing quality initiatives undertaken by the agency in the annual *Minding Our P's & Q's—Performance and Quality* report. This report marks the progress made in supporting the mission of the agency by supplying activities such as updates on the Emergency Room Utilization Project and new and continuing research studies. This report is available on OHCA's website at www.okhca.org/research/annual_reports/Minding_our_Ps_and_Qs.

OHCA'S PERFORMANCE

Following are key measures selected to inform the audience of the evaluation of agency performance in providing quality services and meeting members' needs.



OBJECTIVE:

TO SEEK AND EVALUATE MEMBER FEEDBACK ON SATISFACTION WITH SERVICES RECEIVED WHEN ACCESSING SOONERCARE BENEFITS.

Outcome:

Customer Satisfaction Survey Results
Benchmark – Trend information

What does this measure report?

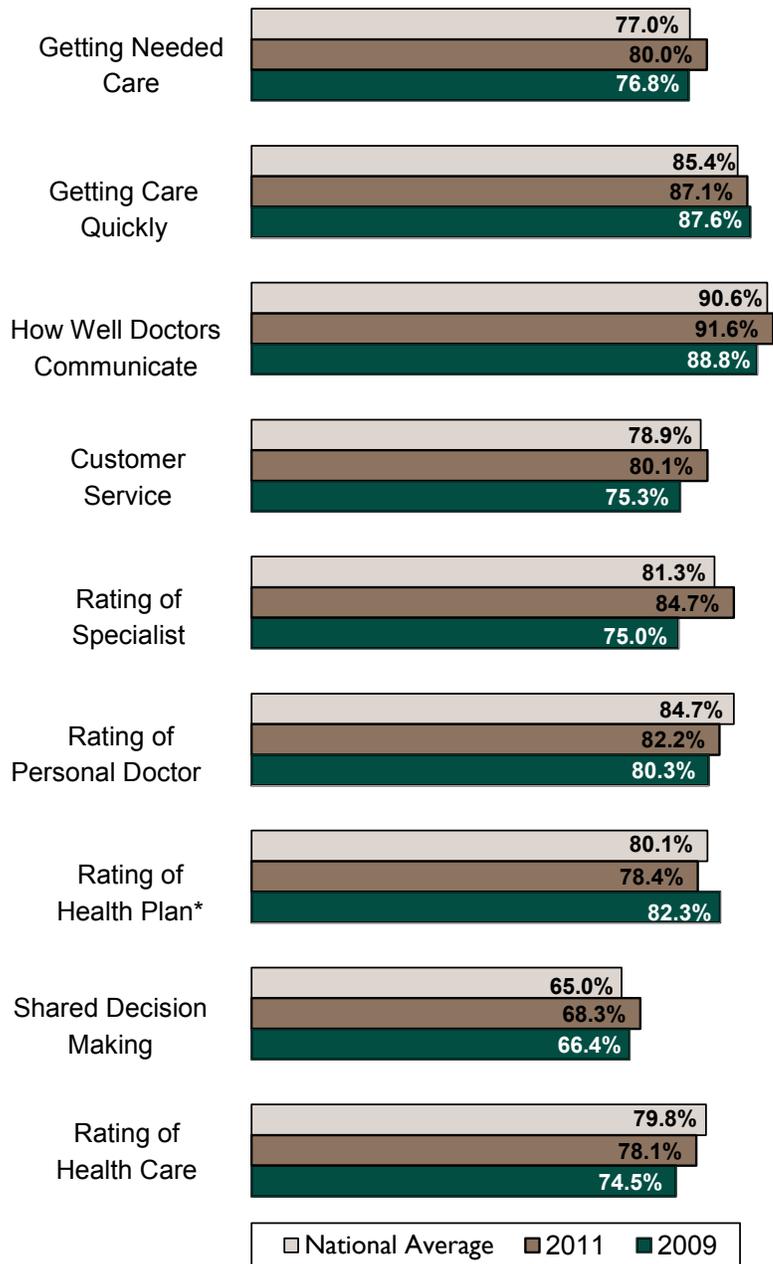
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey, is a survey measuring members’ satisfaction with medical services they received.

Measures range from “Rating of Health Plan” to “How Well Doctors Communicate.” Formerly, the survey alternated annually between the adult and child populations. Effective 2011, the child’s experiences will be surveyed annually due to CHIP reporting requirements. Adults will continue to be surveyed every other year.

It should be noted that the information reported for 2011 was based on surveys of members enrolled in SoonerCare Choice as of November 30, 2010 and enrolled in the program for the six months prior to the survey from June 1, 2010 to November 30, 2010. In order to be included in the sample the member must have been 17 years of age or younger as of November 30, 2010.

Figure 17

Customer Survey (CAHPS®) - Child



Source: CAHPS® Child ealth Survey for SoonerCare Choice, Report for 2011

*SoonerCare is the program being rated by this measure.

What do the latest results mean?

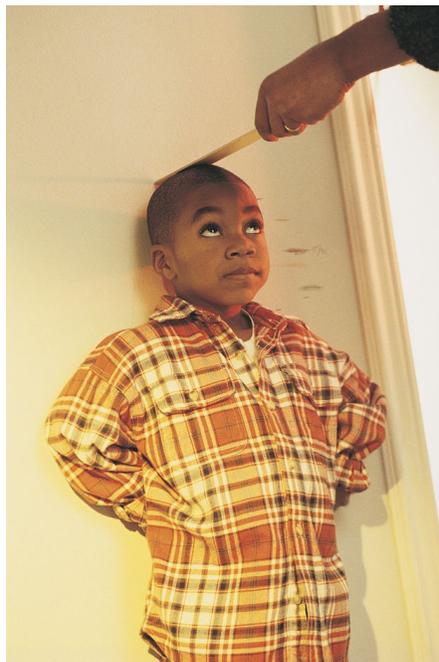
Responding to the survey gives members an opportunity to express their feelings about the program and treatment they received. Issues that come up in the survey may be used as possible training points during provider training sessions. Provider training is discussed in more detail in Goal 6. The responses received from SoonerCare members are compared to a national average. The national average combines data from all participating states as reported by the Agency for Health Research and Quality (AHRQ).

The survey showed that SoonerCare members indicate high levels of overall satisfaction. Six of the nine measures rated, were above the national benchmarks provided.

What is OHCA doing to affect this measure?

The overarching aim is to fulfill OHCA's mission of providing satisfaction and quality. The measures discussed in Goal 2 are instrumental in providing OHCA with member insight. By obtaining this key information, it allows OHCA to target areas for improvement as well demonstrate the effectiveness of other areas. The satisfaction studies, in conjunction with the quality improvement activities completed, ensure that SoonerCare monitors its performance in these areas.

Additionally, a Member Advisory Task Force was created in 2011 to improve the SoonerCare Choice program by receiving input and feedback from members and their families. These meetings are held every other month.



OBJECTIVE:	TO PARTNER WITH OKLAHOMA'S LONG TERM CARE FACILITIES TO STRIVE FOR QUALITY LONG TERM CARE SERVICES.
Outcome:	Percent of 5 star long term care facilities <i>Benchmark – Trend information</i>
Outcome:	Percent of 4 star long term care facilities <i>Benchmark – Trend information</i>
Outcome:	Percent of residents participating in the resident satisfaction survey rating overall quality as excellent or good <i>Benchmark – Trend information</i>
Outcome:	Percent of employees participating in the employee satisfaction survey (including quality) rating overall satisfaction as excellent or good <i>Benchmark – Trend information</i>

Focus on Excellence — What is it?

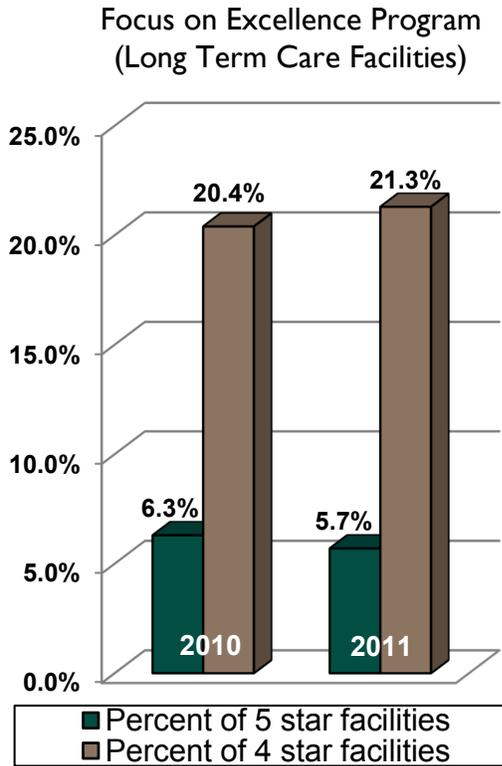
Because of the essential role nursing homes play in the health care system as a result of the long term care they provide, the Focus on Excellence (FOE) program was designed to encourage nursing home improvements in quality, life, and care. OHCA initiated this program in 2007 and continues its focus on facilities established and rooted in Oklahoma. This helps the state with its aim of having top-rated care in its nursing facilities and enhancing the lives of residents as well as their families. All contracted Oklahoma long term care (LTC) facilities are eligible to voluntarily participate in the program and the number of participating facilities has continued to increase to include all Oklahoma nursing facilities with an estimated 95 percent participation rate.

Focus on Excellence utilizes a 1 star to 5 star rating system. The more stars received denotes higher performance rating for the measure. The number of stars a facility has for each measure allows the consumer to compare areas of importance for the family, consumer, and/or loved one. The highest 20 percent of facilities scored receive five stars for that measure while the next highest 20 percent receives four stars, etc., with the lowest 20% of facilities scored receiving one star.

The quality measures are:

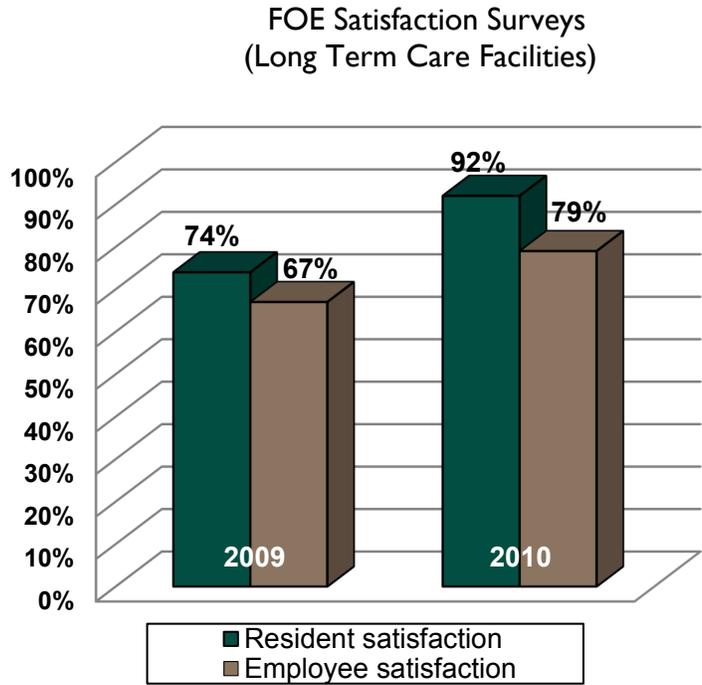
- | | |
|----------------------------------|--|
| 1. Quality of Life; | 6. Nurse Stability; |
| 2. Resident/Family Satisfaction; | 7. Clinical Measures; |
| 3. Employee Satisfaction; | 8. State Survey Compliance; |
| 4. System Wide Culture Change; | 9. Medicare Utilization; and |
| 5. CNA/NA Stability; | 10. Direct Care Hours per Patient Day. |

Figure 18



Source: My InnerView, Inc.

Figure 19



Source: My InnerView, Inc.

Resident/Family Satisfaction and Resident Quality of Life scores are derived from surveys that are administered semi-annually to facility residents and their family members. Employee Satisfaction scores are tallied from responses received from semi-annual surveys mailed to employees. Respondents' opinions have a direct influence on these measures and the response rate has shown an appreciable increase in surveys completed and returned as familiarity with the survey methodology has occurred. Each month, long term care facilities provide information to My Innerview, Inc., as the contractor responsible for the data management of incentive payments and star ratings.

The technology provided gives a facility the ability to compare its performance with facilities across the state. Points are awarded to the facilities that meet or exceed established threshold requirements for the 10 separate quality performance measures; additional Medicaid payments are made to these facilities. These incentive payments can range from 1 percent of the base rate up to 5 percent of the base rate.



What do these measures report?

These measures report the progress the Focus On Excellence program, in partnership with Oklahoma's long term care facilities, have made in the area of quality, life, and care for nursing home residents. With the state's goal of having top-rated care in its nursing home facilities, it is important to examine the percent of 4 and 5 star facilities in conjunction with resident and employee satisfaction.

What do the latest results mean?

All contracted facilities in Oklahoma are encouraged to engage in the program. There is a 95 percent participation rate for Oklahoma nursing facilities. However, the number of 5 star facilities dropped slightly from 2010 to 2011 while the number of 4 star facilities increased slightly during the same time period. Resident satisfaction was considerably higher in 2010 (92%) than in 2009 (74%). The level of employee satisfaction also increased during that time period. Also, the program has experienced a higher response rate as individuals, both residents and employees, became more familiar with the survey.

What is OHCA doing to affect these measures?

A website is available that provides nursing home ratings based on several performance metrics. It can be used as a helpful tool to assist consumers in evaluating facilities and can be found at www.oknursinghomeratings.com.

As indicated above, the technology provided allows long term care facilities to compare their performances with facilities across the state. The incentive payments received, based upon the ratings, allow those facilities that are performing well to be compensated at the highest rate.

The Opportunity for Living Life (OLL) Division organized an advisory board comprised of providers and advocacy groups that met and developed a new set of performance metrics for SFY2012.



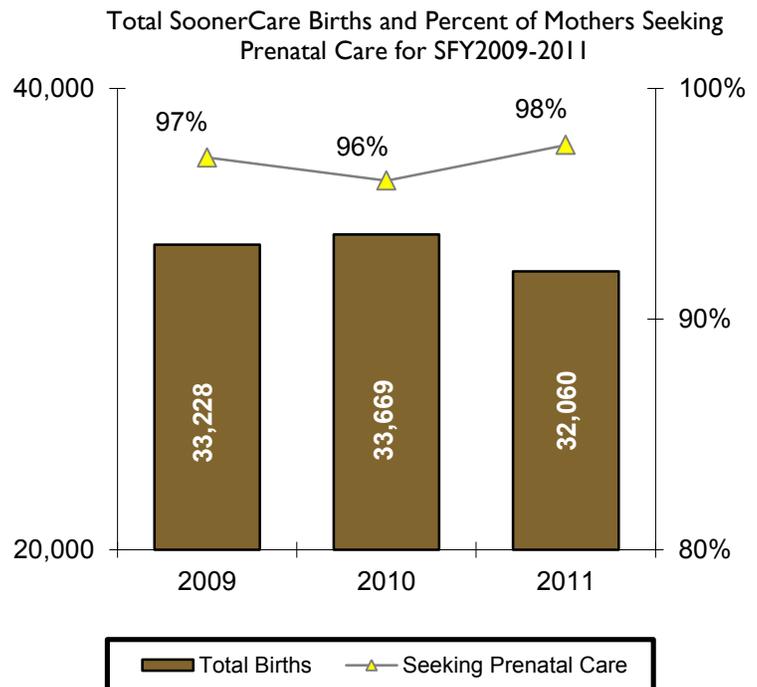


Goal # 3: Members' Personal Responsibilities

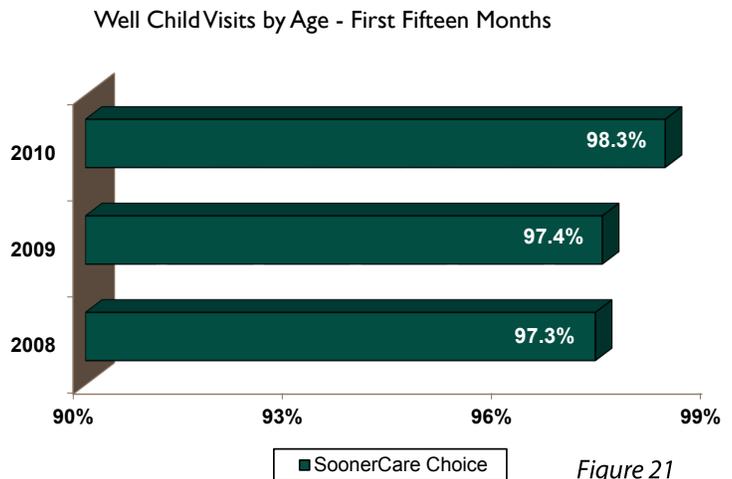
TO PROMOTE MEMBERS' PERSONAL RESPONSIBILITIES FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES.

Performance Highlights

The Performance Highlights provide a concise overview of the agency's progress towards achieving this goal. Performance Measures are provided in this section and include descriptive information as to what a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.



Source: OHCA MMIS Figure 20



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

Figure 21



Goal # 3: Members' Personal Responsibilities

TO PROMOTE MEMBERS' PERSONAL RESPONSIBILITIES FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES.

Being healthy involves making good choices about exercise, diet, and personal behavior. To become healthier, individually, and as a state, Oklahomans must take personal responsibility for their health choices and behaviors. This is particularly true of individuals accessing SoonerCare services. SoonerCare serves low-income populations who are more likely to report themselves in poor health. Professor Sara Rosenbaum of George Washington University states that the Medicaid "...population is markedly less healthy than average."

According to the United Health Foundation, Oklahoma's overall health ranked 48th in the nation, down two spots from 2010. Oklahoma's low ranking is related to conditions that Oklahomans must live with every day, including poverty, limited access to primary care, lack of insurance, and inadequate prenatal care. Oklahoma ranks low in certain categories such as prevalence of smoking and obesity, and OHCA doesn't serve a large majority of those populations. In 2014, when the Affordable Care Act is fully implemented, OHCA may have more of an impact on these populations.

Poor health outcomes can only be improved when Oklahomans take more personal responsibility for their health habits. Properly utilizing health care, following physician's recommendations, and maintaining healthy lifestyles are critical to an individual's health.

OHCA continually seeks to ensure members are taking personal responsibility for their health by providing access to preventive and early intervention services and guiding members as they navigate the health care delivery maze. The Medical Home concept helps providers track their SoonerCare patients' health development and provide better continuity of care (See page 58). OHCA also give providers the opportunity to educate members on how to lead more healthy lifestyles, such as being more active and eating healthier.

In addition to emphasizing healthy behavior, OHCA is also focusing on the operational aspect of personal responsibility in terms of utilization of services. For example, OHCA monitors persistent ER utilization by SoonerCare members. Many of these highly expensive ER visits are unnecessary and the member's primary care physician could have effectively delivered the care being sought. To address this issue, OHCA has developed outreach programs to educate members on their responsibilities as health care consumers. In the

case of persistent ER utilization, simple outreach in the form of letters and phone calls has helped drastically reduce the number of members persistently utilizing the ER. Members receive higher quality care at a lower cost to the state when they visit their primary care physician instead of the ER.



OHCA recently implemented the SoonerQuit Program, which aims to help pregnant women quit smoking. OHCA also partnered with several other state agencies on the Shape Your Future Campaign, which has a goal of improving the health of all Oklahomans.

SOONERQUIT

Smoking before and during pregnancy is the single most preventable cause of illness and death among mothers and infants. An estimated 58 percent of Oklahoma’s SoonerCare population smokes. Women who quit smoking before or early in pregnancy significantly increase the prospects of improved health for both them and their baby.

The Tobacco Settlement Endowment Trust (TSET) has provided funding through December 2012 for the SoonerQuit: Prenatal Tobacco Cessation Initiative. The project utilizes methods proven effective at improving provider’s knowledge of best practice methods and will provide on-site facilitation in integrating these processes into daily routine. OHCA has worked on site with over 21 SoonerCare obstetric care providers. OHCA has also partnered with TSET and OSDH on a media campaign targeting women of childbearing age to encourage them to contact their SoonerCare provider or the Oklahoma Tobacco Helpline for help with tobacco cessation.

SHAPE YOUR FUTURE

In an effort to improve the health of all Oklahomans, OHCA partnered with a large group of healthcare stakeholders to introduce the statewide health campaign called “Shape Your Future.” This program calls



attention to Oklahoma's current poor health status and emphasizes steps that can be taken by government, schools, businesses, and communities to improve public health. These steps are outlined in the Oklahoma Health Improvement Plan (OHIP).



The program was introduced to the public through the "5320" advertising campaign. Signs with the "5320" on them

began appearing across Oklahoma. They were mostly on public rights-of-way or in front of vacant businesses. Soon "5320" was seen on electronic as well as traditional billboards, splashed across the sides of public transit buses, and mentioned on short radio advertisements.

After several weeks of raising interest in the number, the true meaning of the number was revealed. If Oklahoma could match the national average in health indicators, the state would save the lives of 5,320 Oklahomans.

The OHIP has proposed a broad strategy aimed at improving the physical, social, and mental well-being of Oklahoma residents by making changes in three areas: 1) reducing child obesity, 2) improving children's health and nutrition, and 3) reducing the use of tobacco products. Success in these three areas will support health improvement throughout the state

OHCA'S PERFORMANCE

Following are key measures selected to represent OHCA's efforts to assist members in taking personal responsibility for their health and measures that help in assessing members' utilization of OHCA services.

OBJECTIVE

TO STRIVE FOR SOONERCARE CHILDREN TO RECEIVE NECESSARY PREVENTIVE CARE THROUGH CHILD (EPSDT) SERVICES.

Outcome: % of Children Accessing Well-Child Visits—Child Health / EPSDT
First 15 Months - 3 -6 Years - Adolescents

What does this measure report?

This HEDIS measure reports the rate of at least one well-child visit for children enrolled in Oklahoma's SoonerCare Choice health care program. These visits are part of the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program comprised of comprehensive and preventive health services for children. (ages 15 months to 3 years are not calculated).

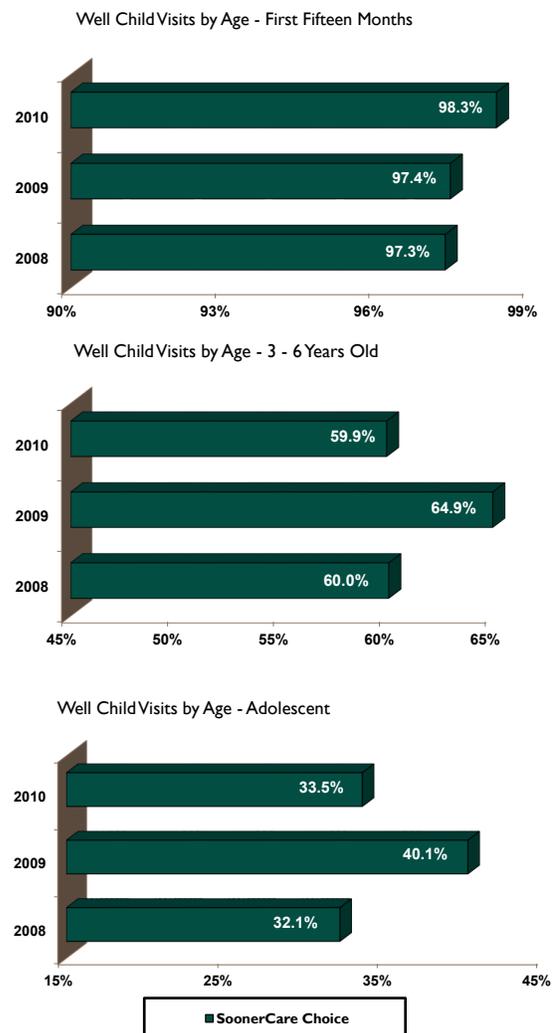
While this measure is reported for SFY2010, OHCA is changing the way the data is reported, and all OHCA HEDIS measures prior to SFY2011 will be restated and available in late 2011. (OHCA and HEDIS do not currently report Well Child Visits from 16 months to 3 years of age.)

*HEDIS, the Health Plan Employer Data and Information System, is a set of standardized performance measures originally developed to compare health insurance plans. CMS has worked with the National Committee for Quality Assurance (NCQA) to incorporate Medicaid – specific measures into HEDIS.

*Historically, OHCA has reported several quality measures calculated by the QA/QI staff using HEDIS calculation methods. OHCA measures were compared to the HEDIS national Medicaid mean and the commercial mean that was provided by the NCQA on a yearly basis. Beginning in SFY2011, OHCA will not have access to NCQA HEDIS data. NCQA is no longer making HEDIS data available to OHCA.

Well-Child Visits by Age—Calendar Years 2008—2010

Figure 22



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

What do the latest results mean?

Babies, kids, and teenagers need to get regular check-ups to stay healthy. Seeing a health care provider on a regular schedule, even when feeling well, may help prevent serious health problems in the future. Children and teens enrolled in SoonerCare should take part in these preventive health care services.



Regular check-ups are one of the best ways to detect physical, developmental, behavioral, and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

Babies in Oklahoma continue to visit their primary care provider for well-child visits at a rate above the national average. As children get older however, their rate of visits fall.

What is OHCA doing to affect this measure?

OHCA is doing several things to encourage members to visit their primary care physicians, including:

- Sending reminder letters to members when well-child visits are due or past due,
- 257,000 quarterly newsletters sent to SoonerCare members
- Child Health Unit staff providing information about well-child visits to OSDH immunization representatives with the hope that these representatives will promote the importance of well-child visits when meeting/talking with providers and members,
- Through a CHIPRA Outreach Grant from CMS, OHCA is working with state and community partners across the state to provide information on well-child visits.

CMS 416: Annual EPSDT Screening Ratio

Screening Ratio	
FY 2007	70%
FY 2008	73%
FY 2009	83%
FY 2010	77%

In SFY2010 (the latest data available), the CMS 416 report reflected that 77 percent of SoonerCare Children are surpassing the expected number of EPSDT visits each year, down from 83 percent the previous year. The national screening goal is 80 percent.

OBJECTIVE TO PARTNER WITH OTHER CHILD SERVING ORGANIZATIONS IN THE STATE TO STRIVE FOR OKLAHOMA’S CHILDREN TO MEET THE FEDERAL IMMUNIZATION GOAL OF 80 PERCENT.

Outcome: Oklahoma’s Percentage Compliance with Healthy People by 2020 Campaign
 $\text{Immunization Rate} - \text{Target} / 80\%$

What does this measure report?

This measure reports the percentage of Oklahoma’s children receiving recommended immunizations in the age group of 19 - 35 months based on vaccination series 4:3:1:3:3:1:4

Doses / Immunizations in the 4:3:1:3:3:1:4 vaccination series are:

- 4 - DTP
- 3 - Polio
- 1 - MCV (measles)
- 3 - Hib (bacterial meningitis)
- 3 - Hepatitis B
- 1 - Varicella
- 4 - PCV

Beginning in SFY2011, OHCA began reporting on the 4:3:1:3:3:1:4 series after reporting on the 4:3:1:3:3:1 series in SFY2010 and the 4:3:1:3:3 series for several years prior. The change in the series measured was due to CDC changing the vaccination series that will now be used to measure compliance with Healthy People by 2020 Campaign to the 4:3:1:3:3:1:4 series.

What do the latest results mean?

Vaccines save lives and protect people against permanent disabilities or death. Before the development of vaccines, thousands of infants and children died or were disabled from infectious diseases such as measles, polio, pertussis (whooping cough), and rubella. Because of vaccines, Oklahoma doctors rarely see diseases that once devastated families and disrupted lives. Unfortunately,



Immunization Rates for Oklahoma and Surrounding States for Calendar Years 2007-2010

Figure 24

	Oklahoma	Kansas	Missouri	Arkansas	Louisiana	Texas	New Mexico
2007	53.3%	64.8%	64.7%	57.4%	66.9%	68.5%	65.4%
2008	56.4%	69.5%	61.5%	64.9%	72.5%	70.5%	72.9%
2009	61.0%	65.6%	58.1%	60.0%	73.4%	65.0%	62.5%
2010	61.6%	65.6%	65.5%	73.2%	69.0%	70.1%	65.4%

Source: Centers for Disease Control, National Immunization Program at www.cdc.gov/vaccines/stats-surv/limz-coverage.htm#chart

vaccine-preventable diseases continue to pose a threat to children in Oklahoma. Vaccination remains a critical health strategy as cures are unavailable for most vaccine-preventable diseases. Young children especially need vaccines early and often to ensure their immune systems are able to respond when needed. Maintaining high childhood immunization levels is vital to assuring the public's health.



Immunization rates in Oklahoma and surrounding states have remained stable, fluctuating only a few percentage points since last year. Immunization rates are often dependent upon the available supply of vaccines and the public perception of the need for vaccinations.

Children that do not receive recommended immunizations are susceptible to life-threatening illness. It is important that OHCA and SoonerCare continue to strive to increase the percentage of children receiving these vaccinations.

What is OHCA doing to affect this measure?

Children enrolled in SoonerCare receive free medical, vision, hearing and dental check-ups, and services. Immunizations are a part of SoonerCare covered well-child visits. The goal of the program is to improve the health status of children by making sure they receive preventive services and follow-through care. Seeing a health care provider regularly, even when feeling well, may help prevent serious health problems in the future.

OBJECTIVE	TO INCREASE PREVENTIVE/AMBULATORY CARE USE BY ADULTS
Outcome:	Percent of Adults' Health Care Use of Preventive / Ambulatory Care

What does this measure report?

This measure reports HEDIS data for adults ages 20 to 44 and 45 to 64 years that have accessed preventive / ambulatory care during the period. Many adults do not seek care until a medical issue elevates to an emergency. Adult health care use is reported as an indication that individuals are participating in their health care by seeking medical services responsibly.



While this measure is reported for SFY2010, OHCA is changing the way the data is reported, and all OHCA HEDIS measures prior to SFY2011 will be restated and available in late 2011.

*HEDIS, the Health Plan Employer Data and Information System, is a set of standardized performance measures originally developed to compare health insurance plans. CMS has worked with the National Committee for Quality Assurance (NCQA) to incorporate Medicaid – specific measures into HEDIS.

*Historically, OHCA has reported several quality measures calculated by the QA/QI staff using HEDIS calculation methods. OHCA measures were compared to the HEDIS national Medicaid mean and the commercial mean that was provided by the NCQA on a yearly basis. Beginning in SFY2011, OHCA will not have access to NCQA HEDIS data. NCQA is no longer making HEDIS data available to OHCA.

Adults use of Preventive / Ambulatory Care by Age for Calendar Years 2008—2010

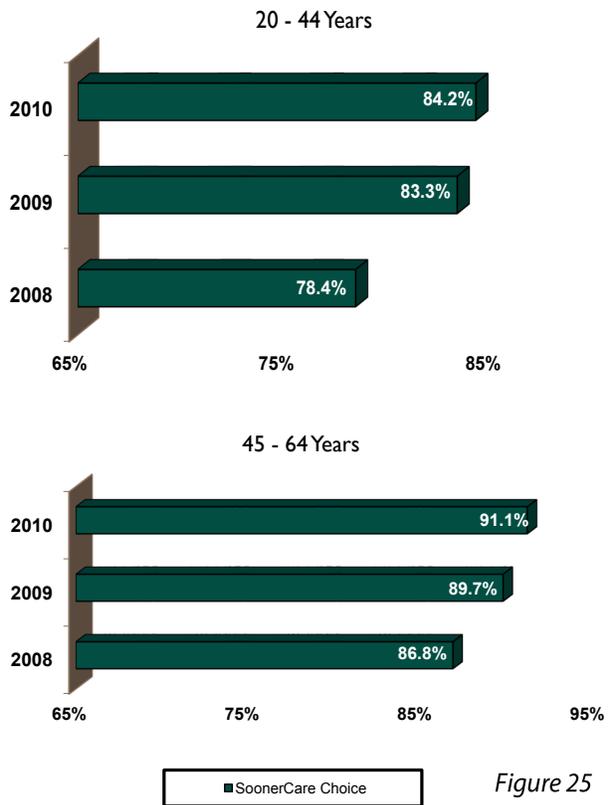


Figure 25

Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

What do the latest results mean?

Access to primary care correlates with reduced hospital and emergency room use while also preserving quality. Studies show that costly and inappropriate care can be reduced through shared decision-making between well-informed physicians and patients. Physicians play a central role in nurturing these quality-enhancing strategies that can help to slow the growth of health care expenditures. Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making access to primary and preventive care services available is one strategy to lower hospital utilization while maintaining the quality of care delivered.

SoonerCare members in the 20 to 44 year old age group and the 45 to 60 year old age group have continued to use preventive/ambulatory care at slightly increasing rates over the previous year.

What is OHCA doing to affect this measure?

In February 2008, OHCA launched the SoonerCare Health Management Program (HMP). The program is designed to benefit SoonerCare Choice members who show a high-risk for chronic disease and their primary care providers (PCP). Predictive modeling software is used to select members who, based on their medical history, are at the highest risk for adverse outcomes.

The HMP uses the chronic care model, in which the main principle is to pair an informed and engaged patient with a prepared and proactive provider in order to create the best possible health outcome. The Nurse Case Management portion of the HMP program emphasizes self-management principles and serves up to 5,000 of our members identified as high risk. The other key component to the HMP is Practice Facilitation, which is support offered to assist the provider in becoming more prepared and proactive.

Initially, the program estimated its targeted group to include 5,000 Choice members. As of June 30, 2011, 4,633 members were engaged in the HMP. Over the life of the HMP, 13,081 members have been enrolled. The Pacific Health Policy Group, an independent evaluator, credits practice facilitation with saving 2.8 million dollars in the first 17 months of operation. Through practice facilitation, one component of the HMP, OHCA has provided services to 82 practices that touch over 100,000 SoonerCare member lives.



HMP SERVICES AVAILABLE:

Nurse Care Management - In person or by phone, a nurse provides education, support, care coordination and self-management tools aimed at improving the member's health.

Behavioral Health Screening - It is very common for members with chronic health conditions to feel stressed or concerned about their health. Sometimes poor emotional health can make the medical condition worse. All HMP members will be asked to complete a behavioral health screening to identify areas they may need help with managing.

Pharmacy Review - Each HMP member fills out a medication list with the help of their nurse care manager. The nurse can ask for this list to be reviewed by a pharmacist if any problems are identified. This will lessen the chance of a medication error.

Community Resources - All nurse care managers are in contact with a resource specialist to help members locate appropriate resources.

Primary Care Provider Involvement - Nurse care managers send monthly updates to their members' PCPs. These updates include self-management goals, progress made, and the health status of the member.

Practice Facilitation - A professional, highly-trained practice facilitator works with participating practices to redesign office systems. This redesign focuses on applying quality improvement techniques in order to improve care delivered to members with chronic conditions.



OBJECTIVE TO DECREASE EMERGENCY ROOM UTILIZATION BY INCREASED USE OF AMBULATORY/PREVENTIVE CARE SERVICES.

Output: Emergency Room Visits Per 1,000 Member Months

Because of a concern that many SoonerCare members may be substituting emergency room (ER) services for acute care with their PCP, OHCA developed a quality initiative to evaluate the ER utilization of SoonerCare Choice members.

Providers. The provider component of the initiative notifies primary care providers (PCP) of the ER utilization of their SoonerCare patients based on paid claims and encounter data. Outreach to providers includes information to assist in developing strategies related to member care.

Twice a year, OHCA’s Quality Assurance Unit sends ER utilization profiles to many SoonerCare Choice PCPs showing office visits and ER visits for the providers’ member panels in comparison to their peers. The results are risk-adjusted to take into account the various acuity levels of the patients to ensure that comparisons are reasonable. Since this project began, twenty five percent of providers notified of high ER utilizing patients have moved to the lowest category.

In addition, a letter is sent to the PCP’s quarterly which list their panel members utilizing the ER. The letter provides PCPs with the dates of members’ ER visits and their diagnoses.

Members. The member element of the project focuses on identifying high utilizing members and educating them on the appropriate use of ER services. The project now concentrates on members with three or more ER visits in a quarter. Those identified are referred to OHCA’s Member Services Unit for intervention. Members with three visits are sent an informational letter that requires no response. Members with more than three visits are sent letters requesting them to contact Member Services for education regarding ER guidelines. Members with 15 visits and above (persistent members) receive letters from the designated ER Outreach Coordinator in Member Services and are asked to contact this representative. If the persistent member does not contact Member Services, OHCA initiates contact with them.



What does this measure report?

This measure reports SoonerCare members' use of ER services per 1,000 member months of eligibility. The data is disaggregated by members qualifying through Temporary Assistance to Needy Families (TANF) and Aged, Blind and/or Disabled (ABD) criteria.

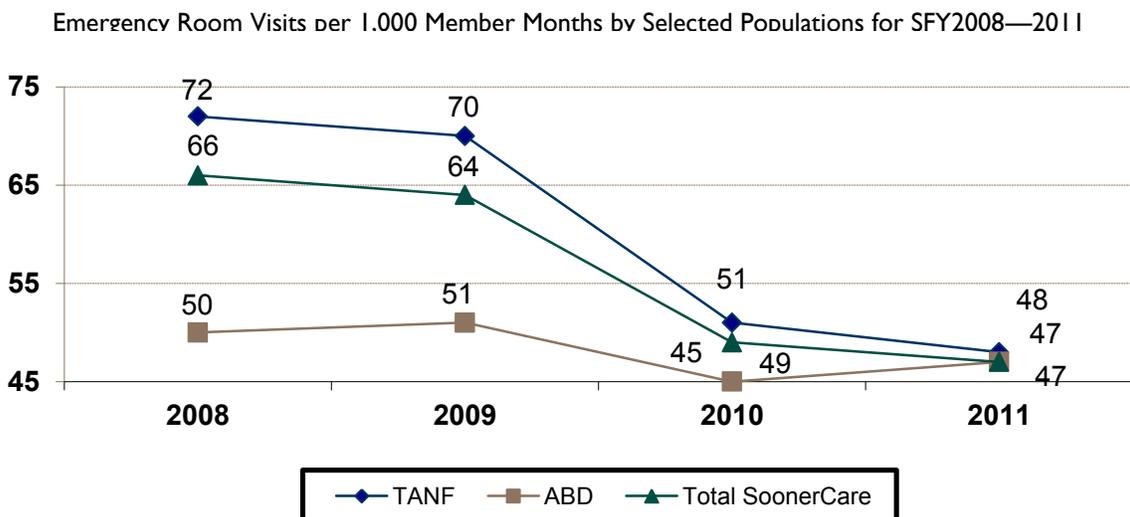


What do the latest results mean?

By law, emergency rooms (ER) are required to provide care to all patients regardless of their ability to pay. As a result, an increasing number of patients seek care in the ER as a substitute for their primary care providers. Inappropriate utilization of the emergency room may result in overcrowding, increased costs, and, potentially, decreased quality of care.

Also, a study released in October 2007 by the Kaiser Family Foundation found that the following characterizes individuals at risk of being high emergency services utilizers:

- (1) publicly insured (Medicare and/or Medicaid),
- (2) chronic health conditions,
- (3) poor perceived health status, and
- (4) lower income.



Source: OHCA MMIS

Figure 26

What is OHCA doing to affect this measure?

The ER Utilization Program continues to provide outreach to SoonerCare members with 3 or more ER visits in a quarter; excluding those ER visits that result in an inpatient stay. Education is offered to all identified members through a letter and/or outreach call to encourage the timely and appropriate use of primary care services in lieu of emergency room utilization.

General Interventions: Every SoonerCare member with 3 or more ER visits in a quarter is mailed an education letter. In addition, interventions are accomplished through telephone contact each quarter. Three telephone attempts are made to contact each SoonerCare member. If telephone contact is successful, the member is encouraged to use the services of the primary care provider (PCP) for routine care instead of the ER.

According to the latest data available from ER OHCA Fast Facts, the ER intervention program has been very successful. From April to June 2010, 1,907 SoonerCare members had 7,891 ER visits. After contacting these members through the ER Utilization Program, this same group of members only had 1,364 ER visits, an 83% reduction.

The ER Utilization Program is responsible for saving OHCA a significant amount of money through cost avoidance. During SFY 2010 (the latest data available), the program avoided costs of \$3.3 million and demonstrated an ER visit reduction of 13,993 from members with continued eligibility in the post-intervention period.

SOURCE: ER Cost Avoidance Report (SFY 2010)



OBJECTIVE TO EDUCATE MEMBERS ON THE USE OF PHARMACY SERVICES AND MONITOR THEIR BEHAVIOR THROUGH THE LOCK-IN PROGRAM.

Output: Average Number of SoonerCare Members Assigned to the Lock-In Program

What does this measure report?

This measure reports the number of members locked into a specific pharmacy due to misuse of services.

What do the latest results mean?

The SoonerCare pharmacy benefit is designed to ensure that members have access to the medications they need for health maintenance. The Pharmacy Lock-In program monitors members who have inappropriately used pharmacy services. Identified members are “locked-in” to one pharmacy to structure their access to pharmacy benefits. Members remain in the program until their behavior becomes consistent with acceptable standards.



SoonerCare members in the lock-in program have increased steadily the last three years. Members are locked-in for two years, and can be extended one year if warranted by a review.

What is OHCA doing to affect this measure?

In order to be assigned to the lock-in review program, an individual must be currently enrolled in SoonerCare or the Insure Oklahoma Individual Plan.

If the member’s utilization is determined to be potentially inappropriate, the lock-in process is started, and the member is required to fill all prescriptions at a single pharmacy. The

member is able to choose a designated pharmacy. This pharmacy is contacted for consent prior to the member being locked-in.

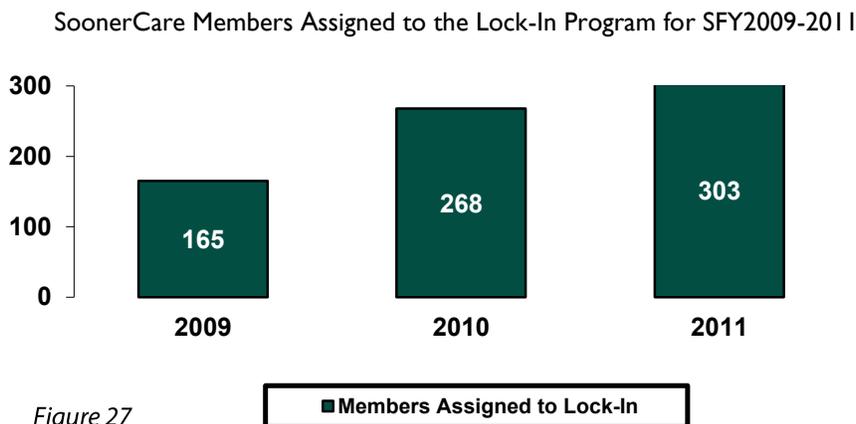


Figure 27

Source: OHCA Program Integrity; Oklahoma University College of Pharmacy

OBJECTIVE	TO INCREASE THE NUMBER OF PREGNANT WOMAN SEEKING MEDICAL CARE BEFORE DELIVERY.
Outcome:	Percent of SoonerCare Members Seeking Prenatal Care—Target / 90%
Output:	Number of Births to SoonerCare Members—Estimate / None
Output:	Number of Members Seeking Prenatal Care



What do these measures report?

These measures track the number and percent of births in which the mother sought prenatal care before delivery. The percentages are disaggregated by the trimester in which care was first accessed.

The method of calculation for this measure was changed for SFY2010, and prior years were restated using the same method. The total number of births did

not change, but the breakdown by trimester was changed from months to weeks.

Previously: 1st Trimester (first 3 months), 2nd Trimester (4-6 months), and 3rd Trimester (7-9 months)

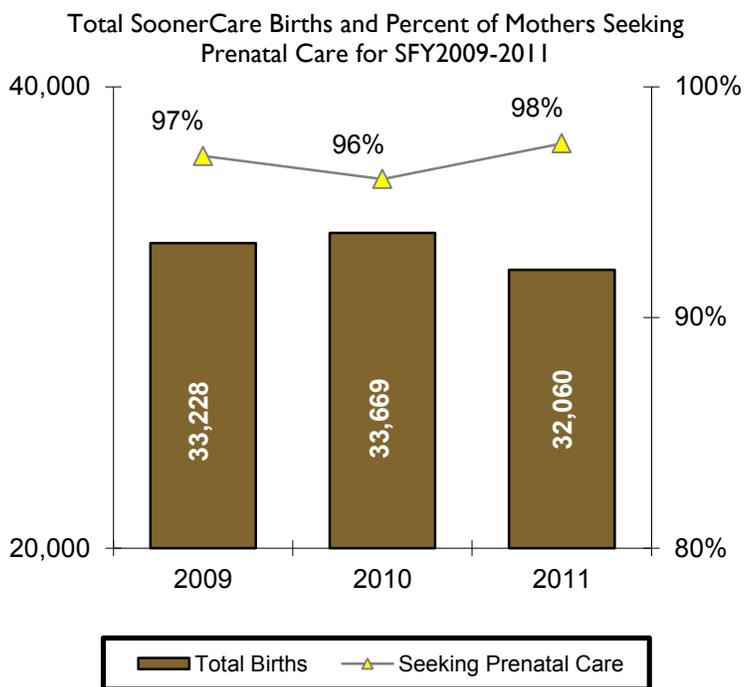
Now: 1st Trimester (first 13 weeks), 2nd Trimester (14-26 weeks), and 3rd Trimester (27-40 weeks)

What do the latest results mean?

Prenatal care is beneficial for all mothers-to-be. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy.

According to the March of Dimes, “The goal of prenatal care is to monitor the progress of a pregnancy and to identify potential problems before they become serious for either mom or baby.” For more information, <http://www.marchofdimes.com/Pregnancy/prenatalcare.html>.

The number of SoonerCare mothers-to-be seeking prenatal care at some



Source: OHCA MMIS

Figure 28

point in their pregnancies in 2010 was 96 percent. The number of women seeking prenatal care in the first trimester of their pregnancies is still drastically below the Healthy People 2020 campaign benchmark of 78 percent. However, the number of women seeking care in the first trimester increased 3.6 percent (53.6 percent to 57.2 percent) from SFY2010 to SFY2011. In Calendar Year 2010, 51,798 babies were born in Oklahoma, 33,125 of them were covered by SoonerCare (64 percent.)

What is OHCA doing to affect these measures?

OHCA continuously seeks to increase the benefits and services available to mothers and babies. Since its first meeting in May 2005, the OHCA-OSDH Perinatal Advisory Task Force has made several recommendations regarding expansion of benefits and services to pregnant women. OHCA has been able to implement many of these recommendations.

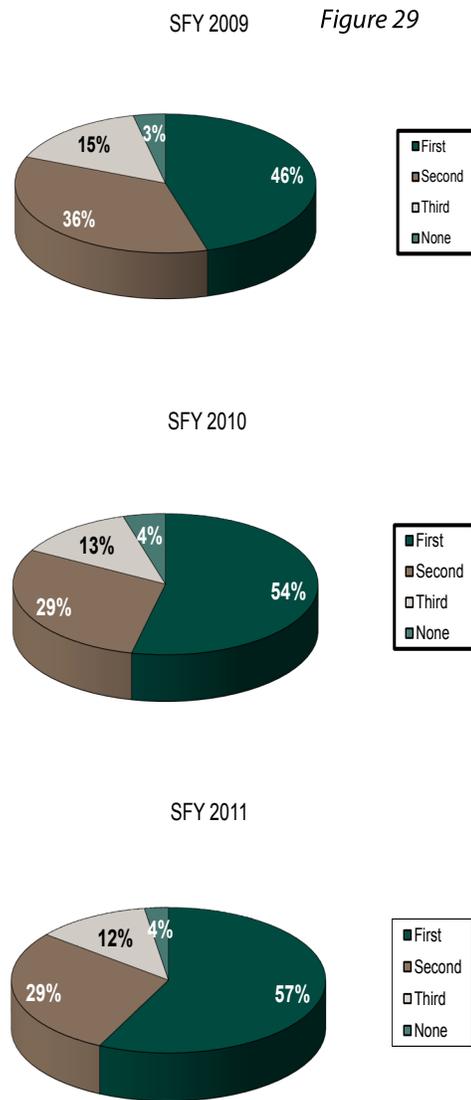
Learn more at [www.okhca.org/about-us/Perinatal Task Force](http://www.okhca.org/about-us/Perinatal-Task-Force).

These changes include:

- Smoking/Tobacco Use Cessation Counseling,
- Ultrasounds,
- Perinatal Dental,
- Prenatal Risk Assessment,
- Obstetrical High Risk Care,
- Maternal & Infant Health Social Work Services,
- Lactation Consultation Services, and
- Genetic Counseling Services.

On March 21, 2011, OHCA launched Fetal and Infant Mortality Review (FIMR), a program aimed at lowering infant mortality rates in the ten worst performing counties in Oklahoma. In 2007, Oklahoma ranked 46th in the country with an infant mortality rate of 8.5 per 1,000 live births. Women who deliver at full term have healthier babies and the costs associated with the birth are much lower. Women come into the FIMR program through online enrollment as early as 6 to 8 weeks into their gestation period. This includes a screening for eligibility into OHCA’s High Risk OB program.

SoonerCare Members Who Sought Prenatal Care - By Trimester - SFY2009—2011



Source: OHCA MMIS

In the program, women receive case management until the end of their pregnancy. Topics addressed in the pregnancy include:

- Access to SoonerRide
- Reminder calls about follow up appointments
- Education about pregnancy-related issues
- Compliance with the prescribed regimen
- Assistance with other related issues regarding medical care



In addition, the women are encouraged to sign up for Women, Infants and Children (WIC) assistance and other needs, such as cribs, car seats, and strollers, are addressed.

As of June 30, 2011, the program had 811 women enrolled. The program continues to grow, adding approximately 100 members per week. While the program is only a few months old, OHCA hopes it will be a factor in lowering Oklahoma's Infant Mortality Rate to the national average of 8 percent.

Newborn case management up to the first birthday is the second phase of the program. Topics addressed in this program for mother and baby include:

- Safe sleep
- Immunizations
- Well child appointments
- Safety in the home for the newborn
- Tobacco cessation





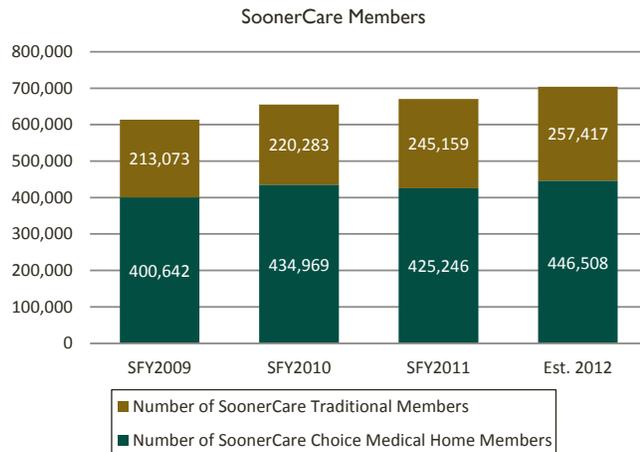
Goal # 4: Member Benefits

TO ENSURE THAT PROGRAMS AND SERVICES RESPOND TO THE NEEDS OF MEMBERS BY PROVIDING NECESSARY MEDICAL BENEFITS TO MEMBERS.

Performance Highlights

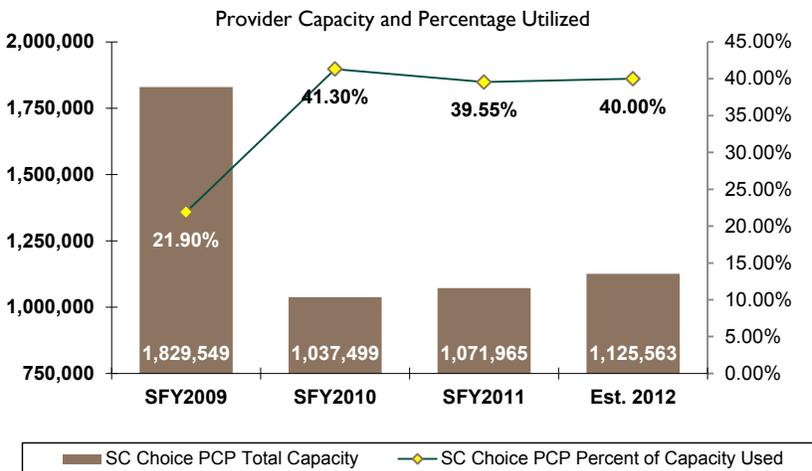
The Performance Highlights provide a concise overview of the agency's progress towards achieving this goal. Performance Measures are provided in this section and include descriptive information as to what a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

Figure 30



These are not unduplicated. Numbers reflect status at a point in time - June 30, 2011. SC Medical Home does not include IHS members

Figure 31



During implementation of Medical Home, providers renewed their contracts with OHCA. Part of the renewal process included a self-assessment that requested updated Medical Home Panel capacity and the number of hours the provider is available for appointments. OHCA staff set Panel capacity maximum limits based on available hours reported. Medical Home primary care providers can now go online and adjust their capacity at any time.



Goal # 4: Member Benefits

TO ENSURE THAT PROGRAMS AND SERVICES RESPOND TO THE NEEDS OF MEMBERS BY PROVIDING NECESSARY MEDICAL BENEFITS TO MEMBERS.

Introduction

In order to receive federal funds, state Medicaid agencies must provide a basic level of benefits to their members. In addition to these basic benefits, federal law provides some flexibility in allowing states to provide additional services. Because of this, OHCA can tailor the SoonerCare benefits package to better address the needs of its members.

For a list of SoonerCare benefits go to <http://www.okhca.org/individuals>

Many factors influence the delivery of medical care to SoonerCare members. The implementation of a Patient-Centered Medical Home (PCMH) model of health care delivery, maintaining a strong and diverse provider network, and the ability of members to appeal decisions related to their care contributes to the effectiveness in which programs and services respond to the needs of SoonerCare members.

Medical Home

At the request of the provider community and in collaboration with the Medical Advisory Task Force, OHCA implemented a patient-centered medical home primary care delivery system on January 1, 2009. This model incorporates a managed care component with traditional fee-for-service and incentive payments. The intent is to build on the successes already achieved in SoonerCare Choice to establish a patient-centered medical home for all SoonerCare Choice members.

Medical Home Principles

The American Academy of Pediatrics introduced the medical home concept in 1967, initially referring to a central location for archiving the medical records of a child. In 2002, the medical home concept was expanded to include operational characteristics.

In February 2007, the AAP, the American Academy of Family Physicians, the American Osteopathic Association and the American College of Physicians used this concept to develop a set of joint principles. These principles address the medical home partnership, in which access is facilitated to specialty care, educational services, out-of-home care, family support,

and other public and private community services important to the overall health of the patient.

Provider Network

OHCA is committed to professional and efficient service while maintaining a strong provider base through recruitment, retention and advocacy for the SoonerCare provider community.

Member Appeals

The appeals process allows members to appeal decisions that may adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, and discrimination complaints.

A coordinated health care delivery system along with a strong provider network and members' assurance of due process ensures members that they will receive the benefits necessary to their health and well-being.



OBJECTIVE	TO ENSURE THAT SOONERCARE CHOICE MEMBERS RECEIVE COORDINATED HEALTH CARE SERVICES THROUGH A MEDICAL HOME
Output:	Number of Members Enrolled in a Medical Home <i>2011 Actual - 439,228</i> <i>2012 Estimate - 461,189</i>
Output:	Number of Members Enrolled in SoonerCare Traditional <i>2011 Actual - 245,159</i> <i>2012 Estimate - 257,417</i>
Outcome:	% of SoonerCare Members Enrolled in a Medical Home <i>2011 Actual - 64%</i> <i>2012 Estimate - 64%</i>

What do these Measures Report?

These measures report the number of SoonerCare members enrolled in medical homes through SoonerCare Choice, the percentage of SoonerCare members enrolled in a medical home, and the number of SoonerCare members enrolled in the SoonerCare Traditional fee-for-service plan.

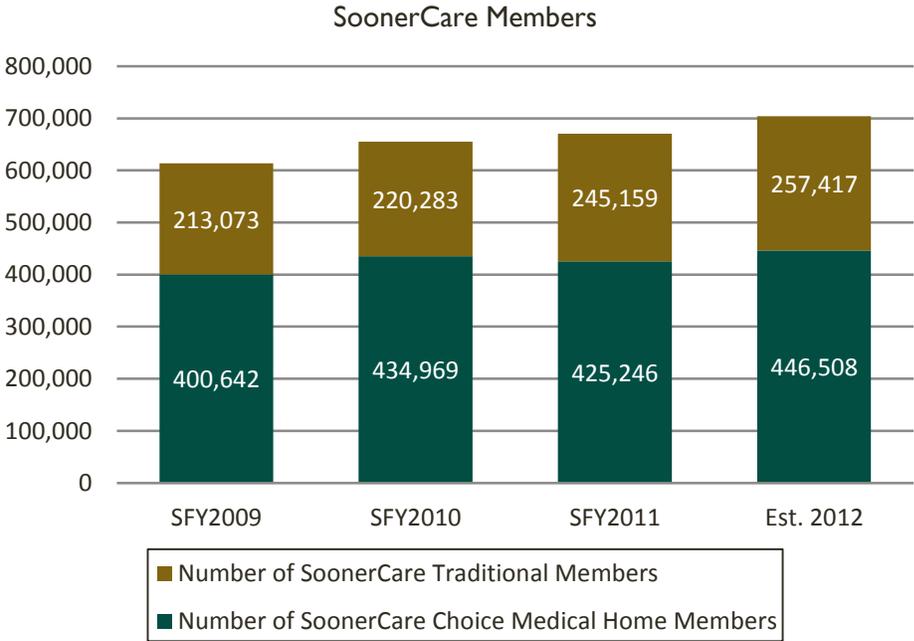
SoonerCare Choice is Oklahoma’s statewide managed care model in which each member is linked to a primary care provider who serves as their 'medical home'. PCPs manage the basic health care needs, including after hours care and specialty referral of the members on their panel. In exchange for this service, each PCP is prepaid a fixed monthly capitated payment for care coordination. Visit-based services are paid under the fee-for-service system.

SoonerCare Traditional fee-for-service has a statewide network of providers that includes hospitals, family practice doctors, pharmacies and durable medical equipment companies. SoonerCare members in this program may choose any of these contracted providers for needed services.

Some members are initially enrolled in SoonerCare Traditional, however only a small percentage remain in the program. They include:

- residents of long-term care facilities;
- dually eligible SoonerCare/Medicare members;
- people with private HMO coverage;
- those eligible for the Home and Community-Based Services (HCBS) waivers;
- children in state or tribal custody.

Figure 32



Source: OHCA Fast Facts

These are not unduplicated. Numbers reflect status at a point in time - June 30, 2011. SC Medical Home does not include IHS members.

What do the latest results mean?

Historically, enrollment has grown steadily from year-to-year. In SFY2011, SoonerCare enrollment continued to grow at a steady pace. The proportion of SoonerCare Choice members to SoonerCare Traditional members also remained consistent at around 2 to 1.

What is OHCA doing to affect these measures?

In some cases, members who qualify for SoonerCare Choice Medical Home are enrolled in Traditional fee-for-service. Every month, those members are identified through an automated process and are sent letters encouraging them to enroll with a PCP. Up to five letters are sent over a period of 60 days. Letters include lists of available PCPs in the member’s area who are taking new patients as well as contact information. Additionally, OHCA Member Services division is available to assist members choose a PCP and transition into a medical home.

OBJECTIVE	TO MAINTAIN A PROVIDER NETWORK THAT CAN ADEQUATELY MEET THE NEEDS OF MEMBERS
Output:	Total Unduplicated Provider Count <i>2011 Actual – 30,113</i> 2012 Estimate – 40,170
Output:	SoonerCare Providers' Total Capacity <i>2011 Actual – 1,071,965</i> 2012 Estimate – 1,201,483
Outcome:	SoonerCare Providers' % of Capacity Used <i>2011 Actual – 40%</i> 2012 Estimate – 38.42%

What do these measures report?

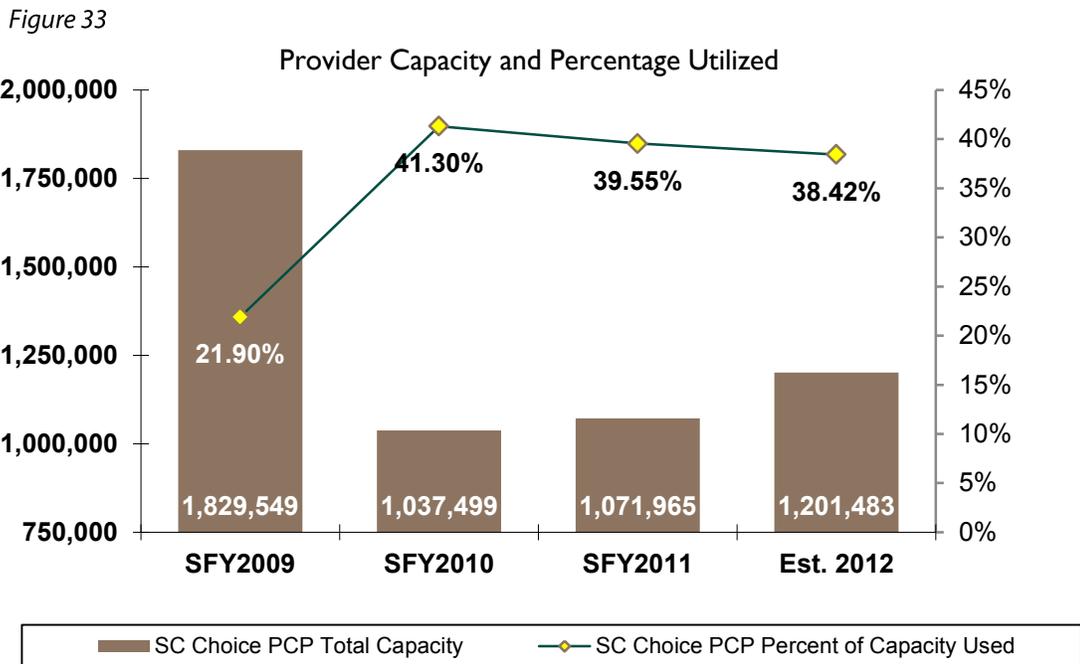
These measures report the number of unduplicated provider ID numbers in the system at the end of SFY2011. They also report the total capacity which is the total number of members that could be served and the actual percentage of capacity being utilized, at the time. Providers specify the maximum number of members they will serve.

What do the latest results mean?

Provider counts and capacity have remained relatively stable over the last three state fiscal years.

What is OHCA doing to affect these measures?

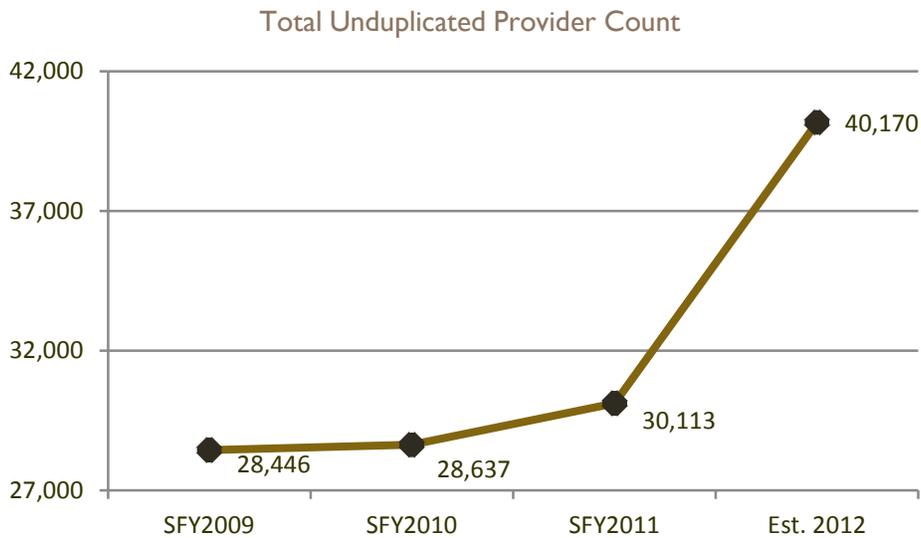
OHCA continues to strive to increase provider participation by streamlining processes and keeping contracted providers as informed as possible. Payment rates are routinely evaluated within constraints of available state and federal funds. Ongoing provider outreach and training is being performed on a daily basis. OHCA also provides a SoonerCare Secure Site as a “one-stop shop” for providers to submit claims, check member enrollment and qualification for services and receive specific information related to their provider type. Pertinent information such as manuals, forms, policy cites and program information can be found by providers in their applicable areas.



Source: OHCA Fast Facts

These are not unduplicated. Numbers reflect status at a point in time - June 30, 2011.

Figure 34



Source: OHCA Fast Facts

Due to federal regulations, the OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement, we now contract with providers that previously billed through a group or agency. Licensed Behavioral Health Practitioners and Mental Health Providers contributed to the increase in the provider counts. This change occurred after SFY2011 ended, but the estimates for SFY2012 demonstrate the impact.

OBJECTIVE TO PROVIDE NECESSARY BENEFITS AS INDICATED BY THE NUMBER OF MEMBER APPEALS WHOSE BENEFIT COMPLAINTS ELEVATE TO THE APPEALS PROCESS

Outcome:	% of SoonerCare Members Filing Appeals <i>2011 Actual – < 1/4 of 1% 2012 Estimate – < 1/4 of 1%</i>	
Output:	# of SoonerCare Member Appeals Filed <i>2011 Actual – 61 2012 Estimate – < 75</i>	
Outcome:	% of OHCA Decisions Overturned <i>2011 Actual – 13% 2012 Estimate – < 20%</i>	

What do these measures report?

These measures report a comparison of member-filed appeals to the total unduplicated count of members enrolled during the year, the number of member complaints related to benefits that elevate to the appeal level, and the percentage of members' appeals in which the agency's initial conclusions have been adjudicated and upon review, have been overturned. The appeals process allows members to have their cases reviewed for legal, regulatory and discriminatory issues. The number of appeals varies from year to year based on relevant issues of the time.



What do the latest results mean?

The relatively low number of member benefit appeals is an indication that in most cases members are receiving care that meets their needs and expectations. Similarly, the low percentage of decisions overturned indicates that policies and rules regarding member benefits are being applied correctly and uniformly in the majority of cases.

What is OHCA doing to affect these measures?

In SFY2010, OHCA began hearing eligibility appeals that had previously been heard by DHS. In SFY2011, the increase in appeals was reviewed and it was found that some appeals relating to eligibility issues were being included in the measure. The measure has been revised to only include enrolled members who file an appeal relating to benefits. The number of appeals decreased significantly due to the appeals relating to eligibility being removed.

It should be noted that the estimates of the number of appeals for SFY2012 and forward should not be considered a goal to achieve. Rather, these estimates should be used as a yardstick for trend analysis.

Figure 35

Member Appeals	SFY2009	SFY2010	SFY2011	Est. 2012
Ratio of Filed Benefits Appeals to Total Beneficiaries	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%
Number of Beneficiary Benefits Appeals Filed	56	158	61	<75
Percent of Benefits Appeals Decisions Overturned	7%	6%	13%	<20%

Source: OHCA Legal Division



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Goal # 5: Responsible Financing / Purchasing



TO PURCHASE THE BEST VALUE HEALTH CARE FOR MEMBERS BY PAYING APPROPRIATE RATES AND EXPLORING ALL AVAILABLE VALID OPTIONS FOR PROGRAM FINANCING TO ENSURE ACCESS TO MEDICAL SERVICES.

Performance Highlights

The Performance Highlights will provide the reader with a concise overview of the agency's performance in this goal. Greater detail will be provided in the section to supply descriptive information on what exactly a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

Cost of Physicians / Other Providers and Rate of Reimbursement Compared to Medicare Rates for SFY2009 - 2012

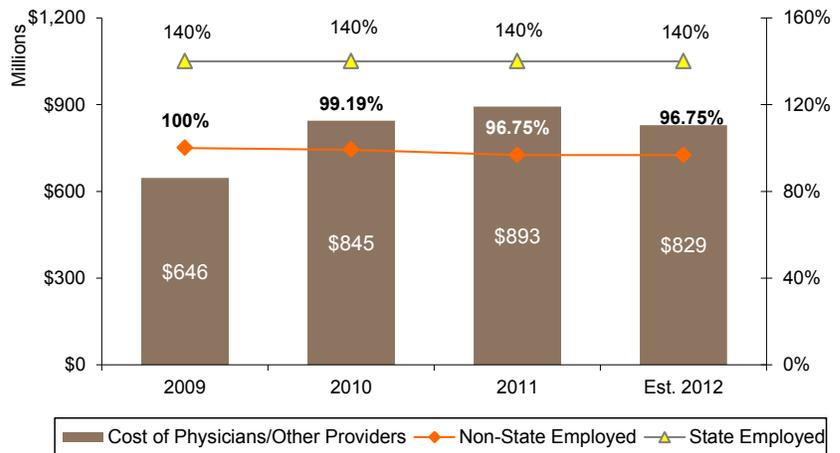


Figure 36

EHR Incentive Payments		SFY 2011
Number of Eligible Professionals Receiving EHR Pmt		592
Cost of EHR Pmts To Eligible Professionals		\$ 12,572,917

EHR Incentive Payments		SFY 2011
Number of Hospitals Receiving EHR Incentive Pmt		33
Cost of EHR Pmts To Hospitals		\$ 22,698,793

Figure 37

GOAL # 5: RESPONSIBLE FINANCING / PURCHASING

TO PURCHASE THE BEST VALUE HEALTH CARE FOR MEMBERS BY PAYING APPROPRIATE RATES AND EXPLORING ALL AVAILABLE VALID OPTIONS FOR PROGRAM FINANCING TO ENSURE ACCESS TO MEDICAL SERVICES.



The cost of healthcare is an issue that OHCA must deal with every day. OHCA faces the challenge of balancing the efficient use of resources with health care providers' need to cover expenses, while keeping current with new medical practices and equipment, and maintaining overall quality. For SFY 2011, OHCA saw only a 1.2 percent increase in expenditures while the number of members served increased by 5.5 percent.

Even as the Oklahoma economy showed signs of improving, the state still faced a budget shortfall of \$725 million for SFY2011. This projected shortfall resulted in OHCA being unable to restore the 3.25 percent cut in provider rates implemented in SFY2010.

In an effort to boost funding for Oklahoma hospitals, in SFY 2011 the legislature enacted the Supplemental Hospital Offset Payment Program. This program assesses some hospitals a 2.5 percent fee on annual net patient revenue based on 2009 cost reports. The revenue generated is then matched by the federal government and used primarily to maintain hospital reimbursement from the SoonerCare program. OHCA projects it will raise an additional \$340 million for hospital payments.

Oklahoma is leading the way in implementing the Electronic Health Records (EHR) incentive program. The program, launched by CMS through funding from the American Recovery and Reinvestment Act of 2009, provides incentive payments to providers to adopt and meaningfully use electronic health records. The Oklahoma EHR Incentive program began January 3, 2011. Oklahoma was the first in the nation to issue an incentive payment to a qualifying provider. The first incentive payment issued to a Tribal Health provider also occurred in Oklahoma.

OHCA will continue to look for ways to provide the best services to members while paying appropriate rates to providers. The following measures report on OHCA's performance related to purchasing health care.



OBJECTIVE	TO REIMBURSE PROVIDERS WHEN APPLICABLE MEDICARE RATES ARE AVAILABLE, AT 100% OF MEDICARE RATES
Input:	Cost of Physicians & Other Practitioners' Services <i>2011 Actual – \$893,069,345</i> Estimate 2012 – \$828,902,342
Outcome:	Reimbursement as a Percentage of Medicare Rates <i>Target – 100% of Medicare Rate</i>

What do these measures report?

These measures track the costs of medical services provided to members. Providers include: physicians, labs, radiologists, dentists, home health care providers, ambulatory clinics, and other practitioners. These measures track costs over time which allows for year-to-year analysis of trends. Reimbursement of costs is also tracked as a percentage of Medicare reimbursement rates for comparison.

What do the latest results mean?

It is vital to the health of SoonerCare members that they have a medical home in which to seek health care services, including advice and education. In order to ensure that SoonerCare providers are able to maintain quality services, ensure technical expertise and utilize current best practices, it is critical that they are reimbursed at appropriate rates.



In SFY2011, non-state employed providers were reimbursed at 96.75 percent of the Medicare reimbursement rates.

The 140 percent rate is paid for services provided by state-employed physicians serving through the Colleges of Medicine at Oklahoma State University and Oklahoma University. The universities pay the state share of cost above the regular SoonerCare reimbursement rates.

What is OHCA doing to affect these measures?

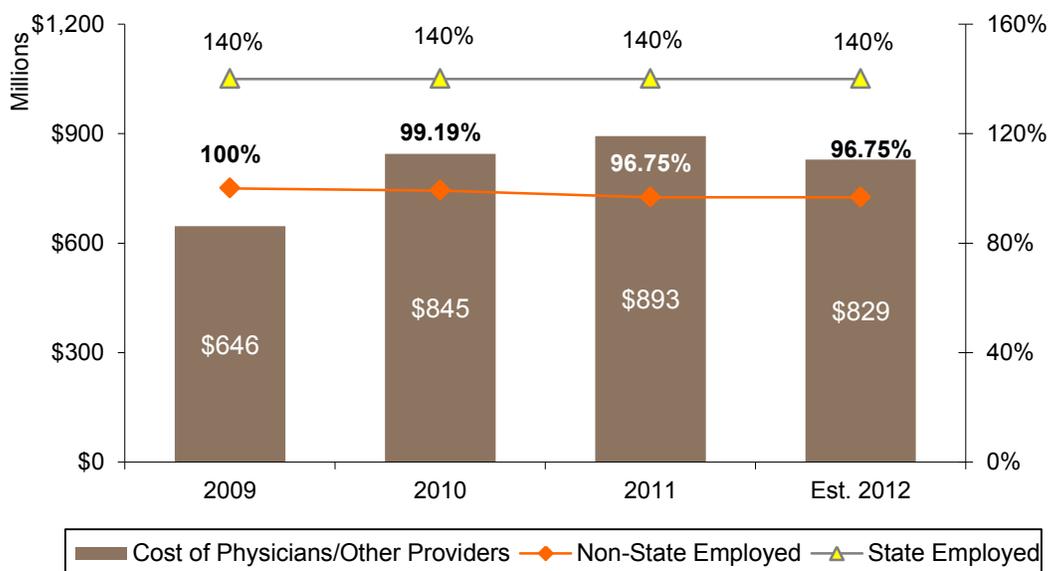
OHCA is committed to reimbursing providers at appropriate rates. In the past, OHCA worked diligently to increase provider reimbursement to 100% of Medicare rates. However, in SFY2010 it was necessary to cut those rates by 3.25 percent. Every effort was made to minimize provider rate cuts.

Providers receive the traditional fee-for-service along with incentive payments like those in managed care models.

Under PCMH, providers receive visit-based payments and additional reimbursements for providing each panel member enrolled these enhanced services and supporting infrastructure. SoonerExcel is the performance-based component that recognizes Primary Care Providers' achievement of quality and efficiency goals. In SFY2011, 91 percent of SoonerCare Choice providers participating in SoonerExcel received incentive payments.

Figure 38

Cost of Physicians / Other Providers and Rate of Reimbursement Compared to Medicare Rates for SFY2009 - 2012



Source: OHCA Financial Services Division

OBJECTIVE	TO REIMBURSE HOSPITAL PROVIDERS A REASONABLE PERCENTAGE OF COSTS
Input:	Cost of Hospital Services <i>2011 Actual – \$906,160,879</i> <i>2012 Budget – \$934,025,971</i>
Outcome:	Reimbursement as a Percentage of Hospitals' Costs <i>Target – 100% of Reimbursable Costs</i>

What does this measure report?

This measure reports the costs incurred by hospitals in providing services to SoonerCare members and the percentage of those costs reimbursed. Hospital reimbursement percentages are based on federally required cost reports provided by hospitals.



What do the latest results mean?

Hospitals have always been a critical component of the state’s health care safety net. In today’s climate of increasing medical costs, coupled with the recent financial recession and ongoing recovery, it is a struggle for hospitals to provide services to a wide range of Oklahomans with diverse medical needs while covering costs and remaining in compliance with state and federal regulations.

The SFY2012 reimbursement percentage estimate assumes implementation of the Supplemental Hospital Offset Payment (SHOPP).

What is OHCA doing to affect these measures?

Beginning in SFY2012, the Supplemental Hospital Offset Payment Program authorizes the Oklahoma Health Care Authority to assess hospitals, unless exempted, a fee equal to 2.5 percent of their annual net patient revenue based upon 2009 Medicare cost reports. The program will generate approximately \$152 million, which will be paid by the hospitals. This money will receive an approximate federal match of \$269 million. Of the total funds, \$338 million will be paid to hospitals as a supplemental payment and \$83 million will be used to maintain current SoonerCare payment rates for providers.

*Hospital Costs and Percent of Cost Reimbursed for SFY2009 - 2012

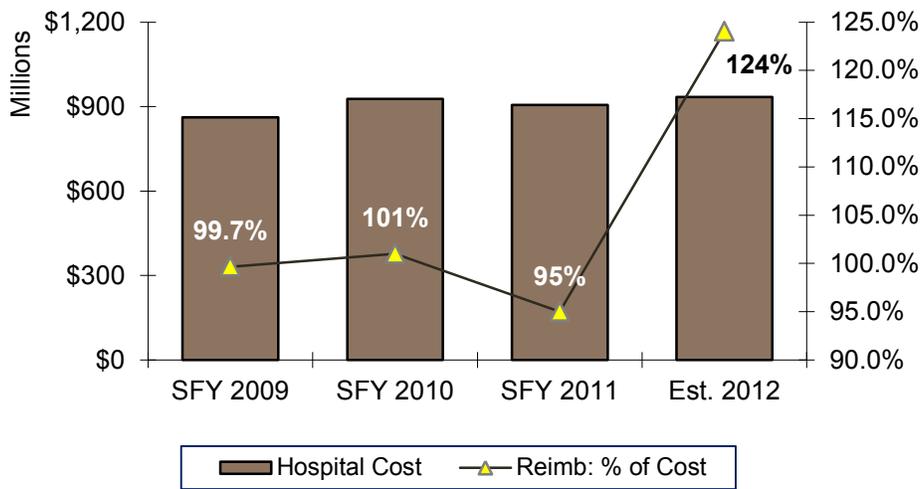


Figure 39

Source: OHCA Financial Services Division

*Both inpatient and outpatient costs are included in 2011 figures and will be included in future years.

OBJECTIVE	TO REIMBURSE LONG-TERM CARE FACILITIES A REASONABLE PERCENTAGE OF COSTS
Outcome:	Average % Reimbursement for Nursing Home Costs per Patient Day <i>2011 Actual – 89.2% 2012 Estimate – 89.2%</i>
Outcome:	Average % Reimbursement for ICF/MR Facility Costs per Patient Day <i>2011 Actual – 100% 2012 Estimate – 100%</i>

What do these measures report?

This measure reports the average percent of reimbursement for long term care facilities’ costs per patient day for both nursing homes and ICF/MRs (Intermediate Care Facility for the Mentally Retarded). Costs are based on audited reports that facilities are required to submit at the end of the fiscal year. Information received following the issuance of the report may result in slight changes to historical data presented.

What do the latest results mean?

OHCA strives to reimburse long term care facilities a reasonable percentage of costs. As the results show, the average rate of reimbursement per patient day for ICF/MR facilities was 100.6 percent for SFY2011. Also, reimbursement per patient day for nursing homes was 89.2 percent for SFY2011.

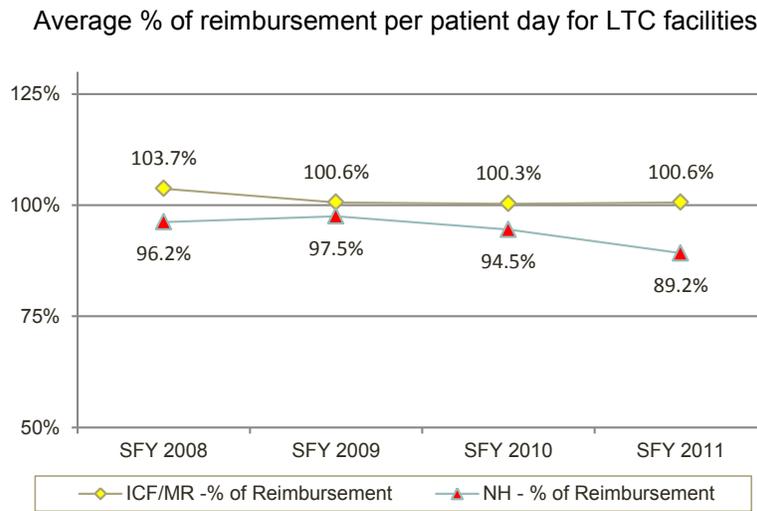
As explained in other sections of this report, the agency was forced to institute a 3.25 percent rate reduction for all SoonerCare providers in SFY2010. This was an unavoidable action due to the agency’s reduced state appropriations and OHCA’s constitutional responsibility of maintaining a balanced budget. The provider rate reduction remained in place through SFY2011 and the impact of the rate change can be seen in the graph presented on the following page. For SFY2009, the average percentage of reimbursement per day for nursing homes was 97.5 percent, demonstrating a decline in SFY2010 that remained through SFY2011 (94.5% and 89.2%, respectively).

What is OHCA doing to affect these measures?

As many as 1.5 million Americans currently reside in nursing homes according to the National Conference of State Legislatures (<http://www.ncsl.org/issues-research/health/long-term-care-faq.aspx>). Medicaid continues to be the main source of long term care financing in the U.S. with estimates that Medicaid is responsible for reimbursing some 40 percent of nursing home care costs. Maintaining sound reimbursement rates to help preserve the stability that long term care facilities provide is a goal of OHCA.

OHCA understands the important function of long term care facilities: providing the best

Figure 40



Source: OHCA Financial Services Division

quality of life for residents. SoonerCare covered the costs for some 21,000 Oklahomans residing in nursing homes during SFY2011 and covered the costs of approximately 2,000 individuals residing in ICF/MR facilities during the same time period.

Currently, the average occupancy rate for Oklahoma nursing homes is approximately 70 percent while the average occupancy rate for Oklahoma ICF/MR facilities is 85 percent . Additionally, about 7 out of 10 nursing home residents' costs are being covered by SoonerCare and 99 percent of ICF/MR facilities' residents' costs are covered by SoonerCare.

It is possible as the population ages that long-term care placements may increase due to illness or disability. The first of the Baby Boom generation turned 65 in 2011 and the number of individuals over the age of 65 is expected to edge up to 71.5 million by 2030 according to a publication by the National Association of Area Agencies on Aging (n4a), "The Maturing of America: Getting Communities on Track for an Aging Population".

The Focus on Excellence program was designed to encourage nursing home improvements in quality, life, and care. OHCA initiated this program in 2007 with the aim of having top-rated care in nursing facilities thereby enhancing the lives of residents as well as their families. Additional Medicaid payments are made to facilities that meet or exceed established FOE threshold requirements for the quality performance measures.

The audited cost reports submitted by long term care facilities at the end of the fiscal year are useful to OHCA in establishing rates, making appropriate budget projections as well as ensuring that current rates are within the upper payment limits established by regulation.



OBJECTIVE	TO REIMBURSE ELIGIBLE PROFESSIONALS FOR PARTICIPATION IN THE ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PROGRAM
Output:	# of Eligible Professionals/Hospitals Receiving an EHR Incentive Payment
Output:	Total EHR Incentive Payments to Eligible Professionals/Hospitals

EHR Incentive Program—what is it?

The Centers for Medicare and Medicaid Services (CMS) has implemented the EHR Incentive program to incentivize eligible professionals and eligible hospitals that successfully demonstrate meaningful use of certified Electronic Health Record technology through the provisions of the American Recovery and Reinvestment Act of 2009.

On January 3, 2011, the Oklahoma Health Care Authority launched the Oklahoma EHR Incentive program as one of the first in the nation. Through CMS, OHCA provides an incentive payment assisting eligible providers in adopting, implementing, and upgrading certified EHR technology and using it in a meaningful way.

The Office of the National Coordinator (ONC) established a certification program to certify EHR systems for use in the EHR Incentive program. Without a certified EHR system, eligible providers will not qualify to receive an incentive payment.

The ultimate goals for the State of Oklahoma are to improve population health and quality of healthcare for Oklahomans; to use clinical information obtained through adoption, implementation, or upgrading of certified EHR technology to measure the health outcomes; and to reduce cost of healthcare by eliminating duplication of services.

What do these measures report?

These measures report the amount of incentive payments made to the total number of eligible professionals and hospitals. The incentive payments are not considered a reimbursement, instead these payments are used to incentivize the adoption, implementation, or upgrade and meaningful use of certified EHR technology.

What do the latest results mean?

Oklahoma was one of eleven states prepared to launch its program in January 2011. Oklahoma was nationally recognized as the first state in the nation to approve a medical doctor for payment through the Oklahoma EHR Incentive Program. In July 2011, delivering the first tribal incentive payment to the Cherokee Nation brought Oklahoma additional national recognition.

By September 2011, Oklahoma was able to report that among participating states it ranked fourth in overall issued payments. For eligible professionals, Oklahoma ranked second in the amount of dispersed funds. Texas ranked first in payments to eligible hospitals while Oklahoma ranked fourth. When examining the ratio of total payments to total Medicaid enrollment numbers for other participating states, including both professionals and hospitals, the degree of participation for Oklahoma is comparatively higher.

Figure 41

EHR Incentive Payments	SFY 2011
Number of Eligible Professionals Receiving EHR Pmt	592
Total EHR Pmt To Eligible Professionals	\$12,572,917

Source: OHCA Financial Services Division

Figure 42

EHR Incentive Payments	SFY 2011
Number of Hospitals Receiving EHR Incentive Pmt	33
Total EHR Pmts To Hospitals	\$22,698,793

Source: OHCA Financial Services Division

What is OHCA doing to affect these measures?

Some of the preparatory actions taken by OHCA staff during the implementation phase of the EHR incentive payments included communication and outreach to the provider community and hospitals. OHCA representatives participated in numerous meetings with associations and providers as well conducting workshops to explain the program and encourage those eligible to participate. OHCA conducted 14 formal training sessions in 2011, showcasing eligibility requirements, the enrollment process, and answering questions about the program. A web page was developed to inform providers of the EHR Incentive program with access to an updated provider manual, publications, and resource links.

Since implementation of the program, over 1,000 calls have been received by the Health Information Technology (HIT) Provider Education Specialist. The inquiries ranged from training requests to assistance with all aspects of the program. Overall, a high-volume of EHR calls/emails have been handled by the HIT staff that work in the incentive payment process: Provider Services, Finance, Provider Audits, Information Services and Legal/Contract Services.

For program integrity purposes, reviews are completed to ensure all requirements of the EHR incentive agreement are followed. Reviews are performed both in pre-payment and post-payment operations.



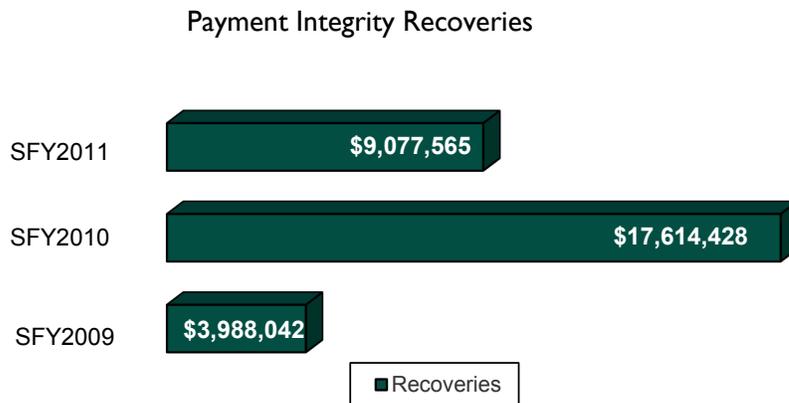
Goal # 6: Administration

TO FOSTER EXCELLENCE IN THE DESIGN AND ADMINISTRATION OF THE SOONERCARE PROGRAM.

Performance Highlights

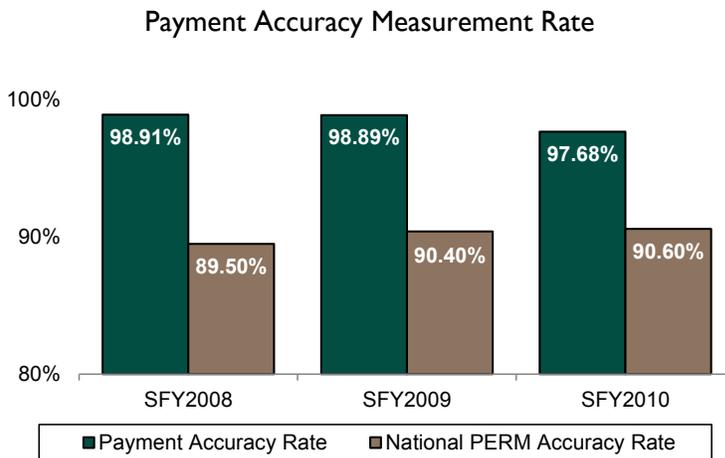
The Performance Highlights provide a concise overview of the agency's progress towards achieving this goal. Performance Measures are provided in this section and include descriptive information as to what a measure means, why it is important, helpful information to offer context, and actions the agency has planned or taken that pertains to the measure or goal.

Figure 43



Source: OHCA Program Integrity Division

Figure 44



Source: OHCA Program Integrity Division



Goal # 6: Administration

TO FOSTER EXCELLENCE IN THE DESIGN
AND ADMINISTRATION OF THE
SOONERCARE PROGRAM.

The Oklahoma Health Care Authority acts as a conscientious administrator over the resources allocated for the administration of the SoonerCare program for the state. OHCA continues to take proactive steps to guarantee that organizational efficiencies are in place to ensure that members are provided access to services while maintaining good relationships with providers.



Accurate forecasting, including immediate and long term, impacts the use of funding and staff for program efficiency. Each year, the agency must estimate and recalculate projections to ensure that the assumptions for the expected number of members enrolled and estimated costs for members are accurately projected. Over 900,000 fellow Oklahomans are depending on the decisions that are made.

SoonerCare does not exist in a vacuum; the program is affected by external and internal factors. Identification of a few of the major elements that influence the administration of the program include: the budget, the number of enrollees, and the local and national economic climate. Unduplicated enrollment increased 9.3 percent from 885,547 in 2010 to 968,318 in 2011 while the unemployment rate in Oklahoma fluctuated from 6.9 to 5.3 percent during SFY2011 according to the Oklahoma Employment Security Commission. The total number of claims paid increased from 31,691,202 in SFY2010 to 34,823,106 in SFY2011. These variables impact the SoonerCare program yet OHCA continues to manage program operations to guarantee the objectives of optimum service delivery and program performance.

The growth and utilization for the SoonerCare program in 2010 increased 10 percent while the program budget decreased by \$71 million, the administrative budget decreased by \$9 million and the general revenues appropriated to OHCA decreased by 5.5 percent. Experiencing this type of funding reduction, the agency was forced to institute a 3.25 percent rate reduction for all SoonerCare providers. This was an unavoidable action due to the agency's reduced state appropriations. This provider rate reduction remained in place through SFY2011. In spite of the reduction, OHCA currently pays 96.75 percent of Medicare provider rates.

OHCA viewed 2011 with many unknowns, but the business of providing health care needed to continue so important assumptions for growth were made, state appropriations increased slightly, and the savings from the continuation of the provider cuts from FY2010 allowed OHCA to file a balanced budget without further cuts.

SoonerCare has experienced exceptional success in holding costs down. As shown in this section of the report, the average per SoonerCare member cost growth for SFY2010 (.4%) and SFY2011 (-4.1%) shows a decrease for the most current year. This is in contrast to the national health insurance inflation figure of 7 percent for 2010 as reported by Towers Watson in their 2010 annual Health Care Cost Survey.

A foundational component of the SoonerCare program is care coordination. The SoonerCare program utilizes care coordination to emphasize preventive health measures as a commitment to improving the overall health of enrollees, preventing avoidable health problems, identifying abnormalities early in the process thereby preventing chronic illnesses, and emphasizing self-management of chronic conditions on a day-to-day basis. Continued participation in SoonerCare HMP, the SoonerCare Care Management Unit, and the SoonerCare ER Utilization program coupled with targeted outreach initiatives such as SoonerQuit and FIMR are a few ways OHCA demonstrates its ongoing commitment to improving health outcomes. As a result, OHCA is able to achieve an overall reduction in expenditures and members can improve their health.

As mentioned in Goal 3 of this report, the Patient Protection and Affordable Care Act (ACA) that was enacted on March 23, 2010, includes provisions that will affect OHCA. Because the new law provides for a significant Medicaid expansion beginning January 1, 2014, planning has already started. These type of planning processes often require extensive involvement by interested parties from planning through implementation. OHCA began implementing portions of the new federal law and planning for the major changes required by the Medicaid expansion in SFY2011.

In 2014, OHCA is expecting approximately 140,000 new members and 30,000 woodwork members at a state cost of \$24 million. OHCA will be taking steps to meet the coming challenges of serving an expanding population eligible for SoonerCare and the associated costs.

OHCA looks forward to the exciting year ahead.



OBJECTIVE

TO CONSISTENTLY PERFORM ADMINISTRATIVE RESPONSIBILITIES WITHIN FUNDING BUDGETED.

Outcome:

Percent of Administration Budgeted Dollars Used
2011 Actual – 89.5% *2012 Target – 100%*

What does this measure report?

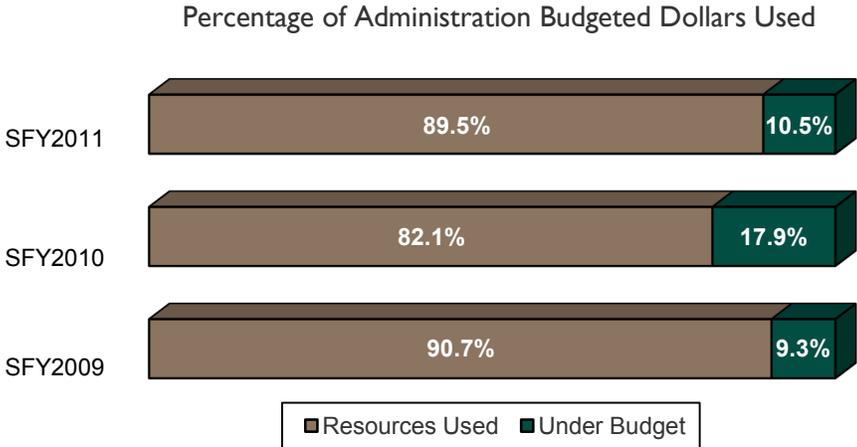
This measure reports the percentage of administration budgeted dollars used.



What do the latest results mean?

Because resources are limited in today’s economy, being good stewards of public funds continues to be a responsibility taken seriously by OHCA. In order to measure how effective the agency is in utilizing its resources, administrative expenses must be tracked and compared to the amount budgeted. This measure is also an indicator of how successful the agency has been at forecasting and planning for the operation of the SoonerCare program. As shown below, the agency’s administrative expenses have remained within budget.

Figure 45



Source: OHCA Financial Services Division

What is OHCA doing to affect this measure?

The state has demonstrated that through careful and precise projections, it was possible to stay within the amount budgeted for the administration of the SoonerCare program.

OBJECTIVE

TO STRIVE TO ACCURATELY PROJECT THE FUTURE COSTS OF PROVIDING HEALTH CARE TO OKLAHOMANS.

Input:

Total SoonerCare Administration Costs

2011 Actual – \$134.2 Million

2012 Estimate – \$168 Million

Efficiency:

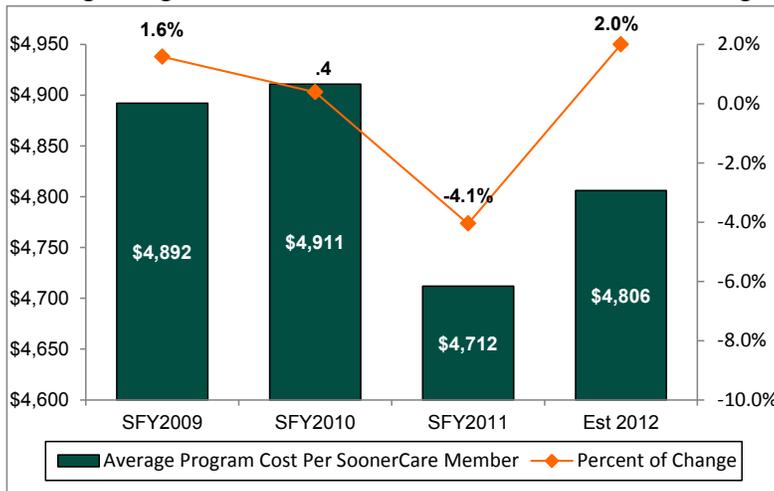
Average SoonerCare Program Cost per Member

2011 Actual – \$4712

2012 Estimate – \$4,806

Average Program Cost Per SoonerCare Member / % of Change

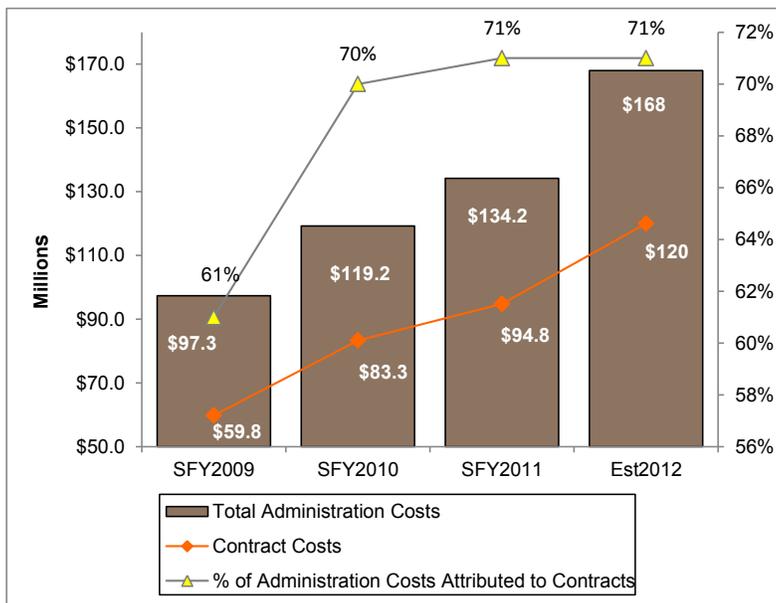
Figure 46



Source: OHCA Financial Services Division and OHCA MMIS

Total SoonerCare Administration Costs / Contract Costs

Figure 47



Source: OHCA Financial Services Division and OHCA MMIS

What do these measures report?

These measures report the average program costs per SoonerCare member as well as the total administrative costs for providing health care to qualifying Oklahomans.

What do the latest results mean?

The SoonerCare average cost per member growth for SFY2010 and SFY2011 (.4 % and -4.1%, respectively) are well below the average national health insurance inflation figure of 6 percent for 2009 and 7 percent for 2010 as reported by Towers Watson in their 2010 Annual Health Care Cost Survey.

OHCA carefully weighs both internal and external factors affecting SoonerCare costs. For SFY2011, the total administrative budget was \$134.2 million dollars with \$94.8 million dollars in contracts with private businesses. Seventy-one percent of administrative costs in SFY2011 can be attributed to contracts with the same percentage anticipated in SFY2012. OHCA has realized the value of engaging in partnerships with the private sector as needed. Contracted services are utilized in daily operations where feasibility, cost-effectiveness, and a high-level of efficiency and expertise can be proven. OHCA monitors its contracts to ensure that agreed upon benchmarks are met.

What is OHCA doing to affect these measures?

The Oklahoma Health Care Authority carefully monitors the expenditure of the resources allocated to the SoonerCare program and works closely with other state officials to ensure responsible stewardship of program funds. Cost information is used to evaluate trends in expenditures, forecast and prepare for future financial needs, and to analyze policy and program effectiveness and efficiency.

Although affected by the local and national economic climate, OHCA diligently managed program operations to ensure the objectives of optimum service delivery and program performance were met. The unemployment rate in Oklahoma fluctuated from 6.9 to 5.3 percent during SFY2011 according to the Oklahoma Employment Security Commission and the SoonerCare program experienced a 9.3 percent increase in unduplicated enrollment from SFY2010 to SFY2011. From SFY2010 to SFY2011, total expenditures increased by 1.2 percent while the number of members served increased by 5.5 percent. It is profound that OHCA was able to realize a decrease in the average program cost per SoonerCare member between SFY2010 and SFY2011 in light of these factors and the national health insurance inflation forecast.

Care coordination is a foundational component of the SoonerCare program. By utilizing care coordination, OHCA is able to emphasize preventive health measures. As a result, OHCA is able to achieve an overall reduction in expenditures and members can improve their health.

OBJECTIVE

TO STRIVE TO ACCURATELY PROJECT THE FUTURE COSTS OF PROVIDING INSURE OKLAHOMA TO OKLAHOMANS.

Efficiency:

Average Cost per Insure Oklahoma Member

2011 Actual – \$3,530

2012 Estimate – \$3,664

What’s does this measure report?

This measure reports the average cost per Insure Oklahoma member. As discussed in Goal I, Insure Oklahoma offers two plans (ESI and IP). IO continues to achieve the objective of providing access to health care for qualifying Oklahomans with unduplicated enrollment totaling 48,226 for SFY2011.

What do the latest results mean?

Figure 48

The IO average per member cost growth for SFY2011 (3.8 %) is well below the average national health insurance inflation figure of 7 percent for 2010 as reported by Towers Watson in their 2010 annual Health Care Cost Survey.

In SFY2009, the ESI plan was made available to businesses with up to 99 employees (formerly up to 50). The program was expanded to offer coverage for full-time Oklahoma college students meeting eligibility criteria. These two changes resulted in a significant increase in enrollment.

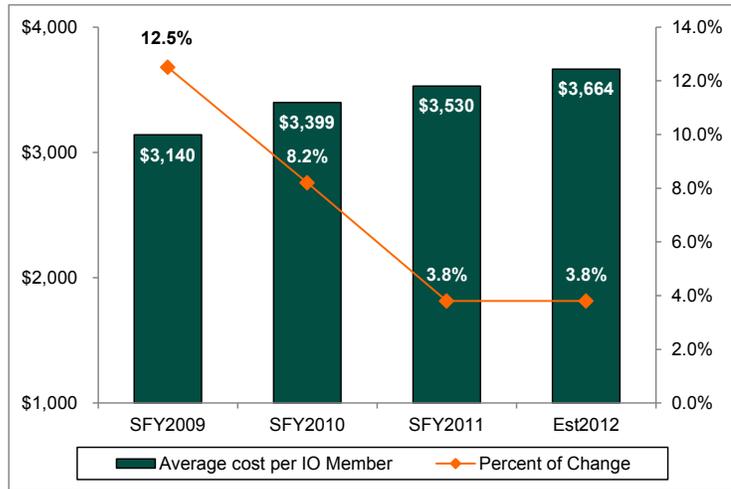
In SFY2010, qualifying dependent children were enrolled in both plans further increasing the enrollment numbers.

The Oklahoma Health Care Authority administers the program and has made affordable coverage available for many Oklahomans meeting qualification guidelines while keeping the average per member cost growth low when compared to the national health insurance inflation figure.

What is OHCA doing to affect this measure?

Insure Oklahoma carefully monitors available funds, expenditures, and the number of enrollees entering the program. Members are provided care coordination by their primary care providers and ER usage is monitored. Outreach is completed for members with 3 or more ER visits in a quarter that does not result in an inpatient stay.

Average Cost Per Insure Oklahoma Member / % of Change



Source: OHCA Fast Facts

OBJECTIVE

TO PAY SOONERCARE CLAIMS WITHIN AN ACCURACY RATE OF AT LEAST 97 PERCENT, CONSIDERING POLICY AND SYSTEMS ISSUES AND MEMBER ELIGIBILITY.

Output:	Number of Claims Paid <i>2011 Actual – 34,823,106</i> <i>2012 Estimate – >5,000,000</i>
Outcome:	Payment Accuracy Measurement Rate <i>Target – >97%</i>



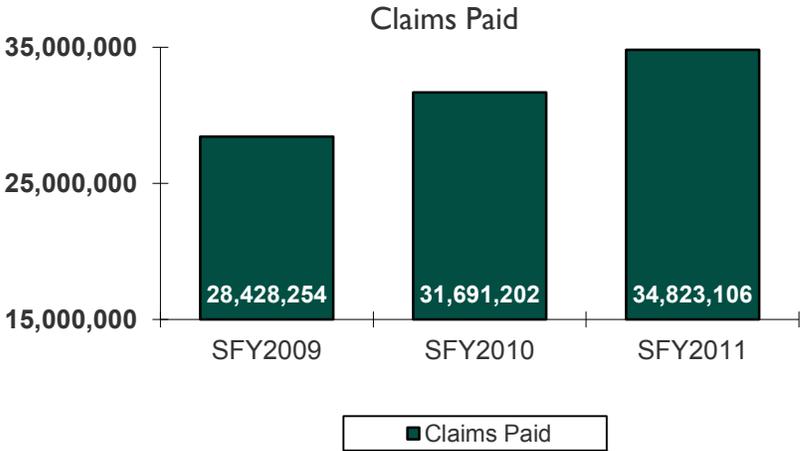
What do these measures report?

The Payment Accuracy Measurement (PAM) reports improper payments in the program and produces a payment accuracy rate. By identifying and measuring payment errors, the agency can take action to correct mistakes and rectify problems.

The Payment Accuracy program does this through a retrospective review of paid claims. A sample of paid claims is randomly selected for review to validate the accuracy of the processed claims, to determine the appropriateness of the documentation submitted for the services provided, and to examine medical necessity for the services performed.

OHCA performs the internal PAM review on an annual basis.

Figure 49

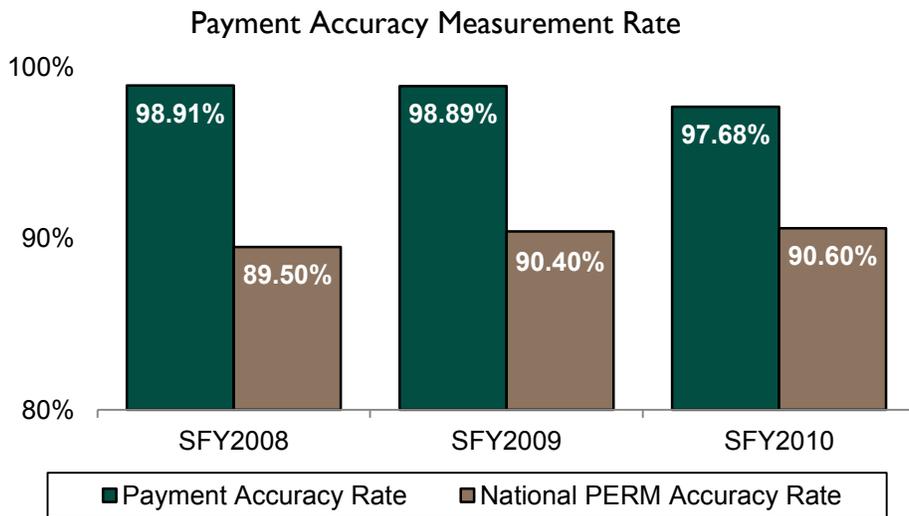


Source: OHCA MMIS

What do the latest results mean?

OHCA modeled its PAM program after the Federal Payment Error Rate Measurement (PERM) program. The Federal program reports an error rather than an accuracy rate. The state undergoes a PERM review every three years. The most recent PERM review of OHCA claims was conducted on Medicaid claims paid in federal fiscal year 2009 and resulted in a 1.24 percent error rate/98.76 percent accuracy rate. Due to changing legislation, the CHIP program was excluded from the 2009 PERM measurement. For purposes of comparison, the National PERM percentages in the chart below were converted to accuracy rates.

Figure 50



Source: OHCA Program Integrity Division

In SFY2010, the internal Payment Accuracy program measured both Medicaid and CHIP programs. The Medicaid PAM rate was 97.68 percent and the CHIP rate was 98.40. The SFY2011 internal PAM rate is still being compiled, the findings will be included in next year’s report.



What is OHCA doing to affect these measures?

The Payment Accuracy program is an integral part of the agency’s program integrity efforts. This program has been instrumental in identifying and correcting areas of concern through provider education, initiation of policy changes, and referrals to other OHCA Program Integrity Units for further review.

Additionally, OHCA continually seeks to generate system improvements. A secure site is maintained on the Oklahoma Medicaid Management Information System (MMIS). This allows SoonerCare providers with internet access to set up an account free of charge. The web site can be easily accessed by navigating to the OHCA home page once the account is initialized. Global messages from OHCA are posted on the first page after accessing the secure web site. The messages may be directed to an individual provider, a specific provider type, or to the entire provider community.

An added system enhancement was developed to assist providers with prompt and accurate payments. The advancement of filing claims online through the secure web site was well received by the provider community. This communication allows the provider to enter the information online and submit the claim electronically. The claim is adjudicated immediately, if successfully submitted, and the claim disposition will display in real time. The provider will receive prompts on any errors received for claims that are denied and the claims can be corrected and resubmitted without delay. This option became available to providers in early 2003. Training and ongoing on-site assistance is made available to providers by the dedicated and professional staff in the SoonerCare Provider Services Department. This is another way that OHCA has responded to the needs of the provider community.

Federal requirements stipulate that OHCA pay 90 percent of all claims within 30 days of receipt. Controls function to ensure that claims do not exceed the federal requirements currently in place. OHCA is pleased to report that 95 percent of claims were paid electronically in SFY2011. The electronic process provides an improved means of claims reimbursement. Further, claims were paid on average within 9.6 days from date of receipt to date of payment. This most advanced level of processing has made filing claims uncomplicated and the real time notification allows the provider assurance that the claims have been completed. OHCA has lead the way through technological modernizations, enhancing operational efficiencies for the agency and the provider network.



OBJECTIVE

TO MAINTAIN AND/OR INCREASE PROGRAM AND PAYMENT INTEGRITY EFFORTS WHICH MAY RESULT IN RECOVERIES.

Output:

Payment Integrity Recoveries

2011 Actual – \$9,077,565

2012 Estimate – \$4,500,000

What does this measure report?

This measure reports the amount of recoupments identified in post-payment and program integrity reviews. It is one of the activities the agency performs to ensure that claims are paid accurately.

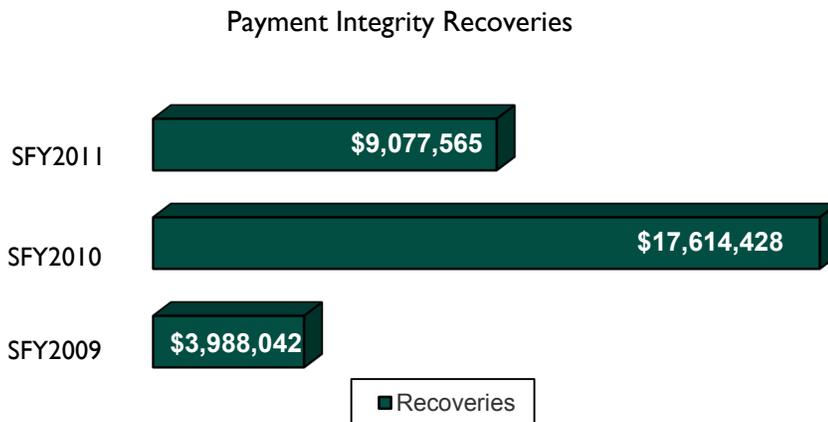
In addition to recoupments identified in post-payment and program integrity reviews, OHCA has also saved money through cost avoidance.

Cost avoidance occurs when OHCA identifies a policy, procedure, billing, or claim issue. If the issue is resolved and results in money not being paid to providers, it is categorized as costs avoided.

Achieving the optimal level of program integrity is a complex undertaking that involves all aspects of program management, from policy development to day-to-day operations. OHCA uses audit and review functions, internal controls monitoring, and prepayment edits to prevent and detect erroneous claim payments and identify suspected fraud and abuse.



Figure 51



Source: OHCA Program Integrity Division

What do the latest results mean?



Actual Payment Integrity Recoveries decreased from SFY2010 to SFY2011, although the estimated amount of recoveries for SFY2011 doubled through demonstrated, effective practices.

Program integrity requires having all available and appropriate policies in place so that the overall program is operating efficiently, including, but not limited to preventing inappropriate payments from occurring and recovering them when they are identified. OHCA understands the impact of unnecessary services, inappropriate billing practices, and noncompliance with OHCA policies and has taken action to decrease these vulnerabilities.

Effective collaboration between the Program Integrity Unit and other OHCA departments promotes the charge that program integrity is everyone’s responsibility.

What is OHCA doing to affect this measure?

Various units within OHCA are responsible for separate areas of potential recoveries, cost avoidance, and fee collection. The Program Integrity Unit safeguards against unnecessary utilization of care and services, performing audits and reviews of external providers in regard to inappropriate billing practices and noncompliance with OHCA policy. Reviews can be initiated based on complaints from SoonerCare providers, members, concerned citizens, or other state agencies, as well as through risk-based assessments.



In addition, OHCA works closely with its federal partner, CMS, in addressing program integrity efforts. The Medicaid Integrity Program (MIP) and the State Program Integrity Assessment program (SPIA) are two examples of activities that have significant resources assigned to them as a result of the Deficit Reduction Act of 2005. These two programs are responsible for an expanded, collaborative partnership with CMS because of the emphasis being placed on balancing the health care needs of beneficiaries while ensuring accurate payments. In an effort to provide support to the states, these programs provide program evaluation and assistance with each state's success in the area of program integrity.

MEDICAID INTEGRITY PROGRAM (MIP)

The Medicaid Integrity Group (MIG) was formed by the federal government to prevent fraud and abuse. This group oversees the MIP, which reviews state Medicaid programs, providers, and members. It also provides technical assistance and training to states.

OHCA underwent a comprehensive review during SFY2011 by the MIG review team. Results of the review were received in August 2011 and five effective practices were detailed which demonstrated OHCA's commitment to program integrity. The first identified practice included the agency's referral process following the CMS *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* guidance. The agency has referred 62 cases over the past four SFYs (2007-2010) to the Patient Abuse and Medicaid Fraud Control Unit (PAMFCU), with all of the cases being accepted. The second highlighted practice was the agency's integration of its program integrity operations throughout the agency, including the Quality Assurance Committee, Medical Authorization Unit, and Policy Department. The third featured practice was the state's MMIS system allowing the provider enrollment section to capture, monitor, and maintain all disclosure information submitted by providers during the enrollment and re-enrollment process. The fourth practice focused on the provider enrollment information being shared among relevant state agencies such as the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS), the Oklahoma Department of Human Services (OKDHS), and the Oklahoma Juvenile Authority. And, the final highlighted practice was the state-developed Payment Accuracy Measurement program that mirrors the Federal Provider Error Rate Measurement (PERM) program.

STATE PROGRAM INTEGRITY ASSESSMENT (SPIA)

SPIA was also created by the MIG to collect standardized, national data on State Medicaid program integrity efforts for the purposes of program evaluation. State profiles will be developed from this data along with performance measures to assess the state's performance in an ongoing manner.

OBJECTIVE

TO ACTIVELY PURSUE ALL THIRD PARTY LIABILITY PAYORS, REBATES AND FEES AND RECOVER OR COLLECT FUNDS DUE TO THE SOONERCARE AND FEDERAL MEDICARE PROGRAM.

Output:

Third Party Liability Collections
2011 Actual – \$43,241,434 *2012 Estimate – \$35 million*

What does this measure report?

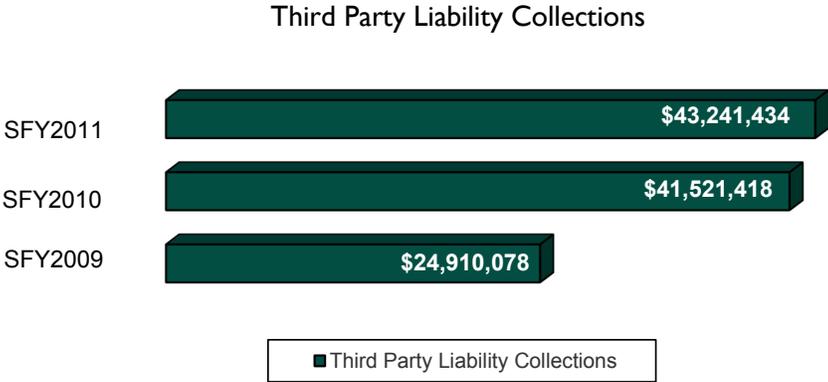
Third Party Liability (TPL) comes into action when other parties have an obligation to pay for medical costs besides Medicaid. By law, SoonerCare is the payor of last resort so it is not considered primary when there is a third party payor. Some common third party payors are private health insurers and Medicare.

When members are enrolled in SoonerCare, they assign their right to third party payments to OHCA. If a claim is paid, OHCA will initiate recovery from the liable third party. This measure reports the amount of dollars collected from third party payors through the “pay and chase” method.

What do the latest results mean?

The measure indicates that the agency is ensuring that appropriate payments and recoveries are made as required by law when SoonerCare resources are utilized. Recoveries continued to increase in SFY2011 over SFY2010 by four percent.

Figure 52



Source: OHCA Financial Services Division

What is OHCA doing to affect this measure?

OHCA hired, HMS, a national contracting firm in 2003. HMS searches its national database of eligibility files for insurers across the nation and adds any verified policies to the OHCA system. They bill private carriers acting as OHCA's electronic billing agent.

This would occur in instances where a policy can't be cost avoided by law or it was discovered after OHCA had already paid a claim on behalf of the member. Cost avoidance occurs if another party is liable but the claim is sent to OHCA first and rejected or information is included to reflect that the TPL has already paid its share or denied the claim. Since OHCA hired HMS, the recoveries have increased substantially as well as the total cost avoidance numbers which have also experienced a dramatic increase.



HMS has joined with Medicaid programs for 25 years to help the programs meet federal mandates and to ensure that Medicaid is the payor of last resort.

OHCA's Third Party Liability Department is comprised of a cost avoidance section, a cost recovery section, as well as a tort and estate recovery section.

OBJECTIVE

TO TRAIN AND EDUCATE SOONERCARE PROVIDERS, BOTH ON AN "AS-NEEDED" AND A PROACTIVE BASIS, THROUGH GROUP AND/OR INDIVIDUAL TRAINING AND OTHER COMMUNICATION.

Output:

- Number of Provider Trainings
- *Seminars/Workshops & Attendees*
 - *Onsite Trainings*
 - *Written Communications*

What does this measure report?

There are several different training opportunities offered to providers. This measure tracks the number of providers who participate in trainings through seminars/workshops, on-site trainings, and written communications.

Figure 53

Provider Training	SFY2009	SFY2010	SFY2011
Seminars/Workshops	149	185	117
Attendees	9,584	11,739	11,672
On-Site Training	4,172	4,043	6,644

Source: OHCA Program Integrity Division

Figure 54

Written Communication	SFY2009		SFY2010		SFY2011	
	Total Sent	Total Providers	Total Sent	Total Providers	Total Sent	Total Providers
Policy Letters	54	608,805	62	291,562	91	213,798
Newsletters	4	83,193	1	18,658	6	13,200
Fax Blasts	25	14,960	14	10,031	24	21,789
Banners	50	970,086	69	941,614	60	848,745

Source: OHCA Program Integrity Division

What do the latest results mean?

OHCA must ensure that providers are billing accurate, necessary, and appropriate claims since a massive number of claims are submitted for payment each year. There are several different training options available to providers: seminars, workshops, bi-annual regional trainings,



on-site trainings, and written communications. Written communication comes in several forms including the following: provider letters, fax blasts, and global messages/banners. These training opportunities cover topics such as: claims processing procedures, new or changing policies, and other topics relevant to the providers' efforts. These forums also give providers the chance to have questions answered.

The number of policy letters fluctuates depending on identified provider types the letters are sent to, the changes that have taken place during the year, and the specific new programs added. The number of different letters produced during the year went up while the number of providers that were actually sent the letters went down.

Provider Services completed nearly 700 more on-site trainings in SFY2011 than in SFY2010. This contributed to the considerable overall increase in on-site provider trainings. Additionally, multiple OHCA units significantly increased their participation in on-site provider trainings for the year.



What is OHCA doing to affect this measure?

OHCA has a strong commitment to its provider community and continues to invest in the established partnership. In a conscious effort to ensure that providers are kept up-to-date with program changes and policy clarifications, OHCA fosters multiple methods of outreach such as print, web, and training videos.

OHCA has Provider Training Videos on the OHCA web site now. These videos contain information regarding current policy and procedures. The videos can be accessed at www.okhca.org/about-us/trainings under Providers homepage and then Training.

A quick and efficient method of transmitting correspondence is now an option for providers in the SoonerCare program: letters can be received by email, fax, and through web alerts. OHCA is replacing paper with computer-generated documents when possible. To participate in the GO GREEN mission, OHCA must have a provider's current email address and/or fax number. For the web alerts, a website banner on the OHCA secure site will notify providers of newly posted letters and include a link to the letters.



This change will save the agency postage costs and costs associated with preparing correspondence for mail out.

OBJECTIVE

TO ENSURE MEMBERS AND PROVIDERS HAVE ACCESS TO ASSISTANCE THROUGH MEMBER AND PROVIDER SERVICES.

Output:

Number of Member and Provider Calls

2011 Actual – 515,935

2012 Estimate – >530,000

What’s does this measure report?

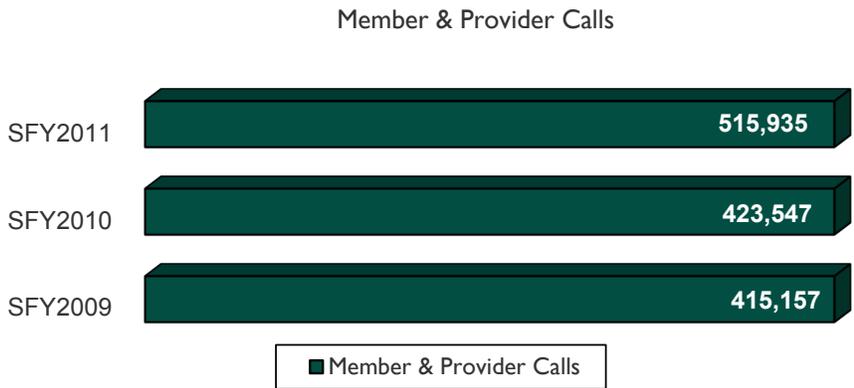
This measure reports the number of calls answered by OHCA Provider Services and Member Services along with the agency’s fiscal agents Hewlett-Packard, Co. (HP) and LifeCare Health Services, LLC. (LifeCare). HP is the first line of contact and answers questions regarding general program coverage and claims processing for providers while LifeCare is the first line of contact for Member Services. Provider Services researches and answers the more complex questions transferred to them as does the Member Services Unit.

Tracking this measure illustrates to the taxpayers of Oklahoma that OHCA is available to assist both SoonerCare members and providers.

What do the latest results mean?

There is no target set for the number of calls answered, although the number has continued to increase each year since 2004.

Figure 55



Source: OHCA Call Tracking Integration System

What is OHCA doing to affect this measure?

OHCA understands that it is very important to its providers and members to be able to speak to a representative concerning their issues. Therefore, departments are dedicated to that service.



OBJECTIVE

TO MAINTAIN A QUALITY PROVIDER COMMUNITY BY FOLLOWING APPROPRIATE PROCEDURES TO IDENTIFY NONCOMPLIANT PROVIDERS AND DETERMINE THE APPROPRIATE COURSE OF ACTION TO RESOLVE ISSUES.

Output:

Number of Involuntary Provider Contract Terminations
2011 Actual – 36 *2012 Benchmark – < 55*

What does this measure report?

This measure reports the number of SoonerCare providers with whom contractual relationships were ended due to noncompliance or rendering services that were not provided in an appropriate and/or necessary manner.

OHCA does not set a target for this measure to achieve, but a benchmark to stay beneath. Due to increased oversight of SoonerCare providers by OHCA and other entities, including the federal government, it is difficult to project the number of providers that may be terminated in future years.

What do the latest results means?

The number of terminated provider contracts decreased from 2010 to 2011.

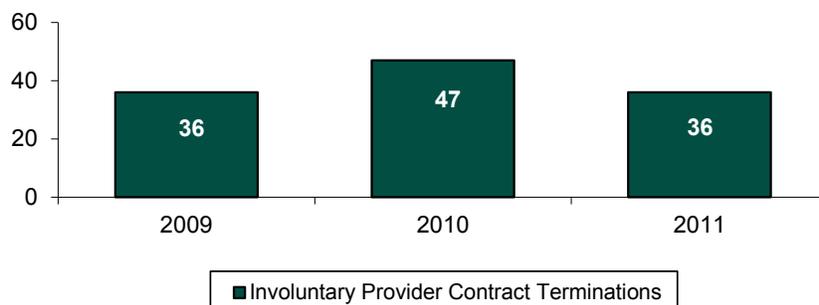
SoonerCare provider contracts are terminated in the following circumstances: 1) if they are identified through program integrity efforts as not meeting quality standards, medical necessity, or contractual requirements, 2) if their license is suspended or revoked, or 3) if they appear on a federal or state exclusion list such as OIG Medicare Exclusion Database (MED).

What is OHCA doing to affect this measure?

OHCA contracts with a variety of providers in a number of specialty areas to ensure members have access to appropriate, timely, and quality care. Having access to a member’s doctor or dentist of choice can add a sense of satisfaction and encourage the relationship necessary to maintain the best possible health.

Figure 56

Involuntary Terminations of Provider Contracts



Source: OHCA Reporting & Statistics Unit

Quality care and integrity of operations are key factors in ensuring a positive outcome for a patient. Specific requirements outlined in the provider contract must be met in order to maintain a working relationship with OHCA and serve our members. When noncompliance or unsatisfactory quality of services is identified and remains unresolved by the provider, OHCA terminates the provider contract.

OHCA communicates with and educates providers in many ways. Through formal training events, individual office visits, a dedicated helpdesk line, and written and electronic communication, OHCA keeps providers informed of policy issues, procedural instructions, and relevant topics to ensure providers have what they need to successfully serve SoonerCare members.

The QA/QI Department receives from 20-40 provider complaint referrals weekly. The referrals that are received come from a myriad of sources: 1) other departments within OHCA, 2) members, 3) providers, 4) legislators, and 5) review findings completed by OHCA. The QA/QI Department reviews medical records when the referral is centered on quality issues and forwards complaints to other areas of OHCA when the referral falls outside the scope of the QA/QI Department. When quality issues are identified with a provider, OHCA refers the provider to the agency's Quality Improvement Organization, Telligen, for peer to peer education and assistance with a corrective action plan.

OHCA has a Quality Assurance Committee that was formed in 2004 and is comprised of key members of the agency. Committee members are staff physicians, nursing professionals, and other agency representatives. Regularly scheduled meetings are held each month with impromptu meetings as necessary. Primarily, the meetings focus on individual cases, but diverse and targeted program issues are also covered to maintain quality control. All information that could impact a provider's status is given to each group member for review. A provider may be terminated from the SoonerCare program by decision of the committee for issues surrounding the quality of care supplied as well as inappropriate utilization of SoonerCare services.



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Supplemental Information

OHCA originally developed the SEA Report for two reasons. The first was to deliver timely, accurate data that can be used for designing programs, managing services, setting policies, budgeting, and improving results. The second was to inform stakeholders about how the agency is meeting its purpose of maintaining or improving the wellbeing of its citizens and is achieving specific goals and objectives related to that purpose.

Reliability. The information included in this report is only as good as the data itself. OHCA has many accountability controls and oversight procedures in place to monitor the integrity of the data. Where performance measures are reported, the source of the data will be reported as well. This will allow the user to gauge the reliability of the information.

Medicaid Management Information System (MMIS). The MMIS refers to the complex data processing system through which SoonerCare and Insure Oklahoma claims are paid. Much of the data reported in the performance measures come from the MMIS. The MMIS processed over 35 million claims in SFY2011.

PROGRAM INTEGRITY AND ACCOUNTABILITY DEPARTMENT (PID)

PROVIDER AUDITS UNIT

Reviews providers for appropriate reimbursement based on federal and state policy, medical necessity, and utilization.

PAYMENT ERROR RATE MEASUREMENT UNIT

Performs payment accuracy measurement functions (internal and external PERM processes) and reviews internal controls, operational effectiveness and efficiency.

CMS Certification. OHCA’s MMIS system has been certified by the Centers for Medicare and Medicaid Services (CMS). CMS found it to be efficient, economical, and effective for the administration of funding. Because of the certification, OHCA receives a higher federal funding match rate for specific administrative expenditures.

SSAE 16 Audit. Annually, the MMIS system undergoes an audit conducted by an independent audit firm. Policies and procedures designed to ensure accurate payment of claims through the MMIS system are reviewed. It is an in depth evaluation and test of controls to ensure they are working as intended and performing effectively. In the 2011 SSAE 16 Audit, Clifton Gunderson LLP stated that controls were described fairly, were in place during the audit period, and are designed to provide reasonable assurance that control objectives can be achieved.

Federal Accountability. As the state agency designated to account for Medicaid funding, OHCA undergoes close federal scrutiny. The Centers for Medicare and Medicaid Services (CMS) is the federal entity responsible for OHCA’s oversight.

CMS Reviews. CMS reviews OHCA’s quarterly statements to ensure the “prudent use of program funds” and a “reasonable degree of assurance” that federal resources are used in accordance with the Social Security Act and Oklahoma’s State Plan. Additionally, OHCA is

reviewed on an ad hoc basis to ensure appropriate application of policy and procedures related to federal funding.

Medicaid Integrity Program Audit. The Deficit Reduction Act of 2005 emphasized the need to ensure Medicaid funding is diligently monitored for fraud and abuse. The Medicaid Integrity Group (MIG) was created to identify various strategies to support and improve the states' program integrity functions.



According to the federal guidelines, states will be reviewed once every three years on program integrity procedures such as provider and utilization audits and provider enrollment procedures. OHCA was reviewed in the fall of 2010 for the federal fiscal year (FFY) 2010. OHCA received a positive audit report for FFY2010 with four minor findings which have been corrected. The agency was also recognized in the report for five effective practices that impact program integrity.

Payment Error Rate Measurement (PERM). Oklahoma was one of the first states chosen for the federal Payment Error Rate Measurement (PERM) review. SoonerCare claims were reviewed for medical necessity and payment accuracy. For FFY2009 (the latest data available), OHCA's error rate was 1.24 percent compared to the national average of 1.89 percent. The results are reported in the Goal 6 section, (page 83) which contains more information about the federal review.

State Accountability. OHCA is audited annually under the Single Audit Act. All state entities receiving federal funds are reviewed to ensure that the resources were spent according to the parameters under which they were granted. The State Auditor and Inspector (SAI) conducts the review and the most recent Single Audit Report is available on their website at www.sai.ok.gov under annual audits.

Internal Accountability Controls. OHCA's Program Integrity and Accountability Department (PID) is located in the Policy, Planning and Integrity Division. The PID staff works closely with other departments within the agency to ensure that program integrity is maintained.

Similar to the federal PERM review, which is performed every three years, the agency conducts an intensive internal review on an annual basis. For the SFY2010 internal review, the agency reports a 98 percent payment accuracy measurement (PAM) rate. Details on this measure can be found on page 83.

OHCA BOARDS AND COMMITTEES

Learn about OHCA Boards and Committees including meeting dates and agendas on our website at www.okhca.org/about-us/boards-and-committees.

Consistency. The agency reports the same performance measures from year to year to provide consistent and reliable information over time. When the agency determines a more appropriate measure should be reported or a change in the method of calculation is needed, the change will be explained in the narrative and the impact of the change will be explained.



In this year’s report, several new measures are being introduced, while others are being eliminated. OHCA will attempt to present historical data for new measures whenever possible, and will identify a new measure with a notation and all necessary background information.

Due to the OHCA budget request being finalized before the release of this report, there may be a difference in numbers presented. The two publications may be completed at different times. Performance data is released in the budget request due to the State in October. Any differences subsequently identified will be explained within this report.

Public Forums. To be sure OHCA stays in line with the expectations of its constituents, OHCA offers many forums to allow the public an opportunity to weigh in on the issues that matter to them.

Annual Board Retreat. Every year in August, the Board of Directors, agency management, and key personnel gather away from the office to focus on plans for the coming year. The meeting is open to the public and an increasing number of stakeholders outside of the agency have attended the last several years. Attendees have included elected officials, other agencies’ directors, commissioners and key staff members, providers and provider associations, and individuals and organizations representing members including Native American tribal representatives.

The retreat offers information about national and local issues that are affecting health care and/or OHCA, updates on agency projects and programs, and an open forum to discuss issues to be considered in current and future planning. The retreat coincides with the state budget process, allowing the agency to incorporate outcomes from the meeting into the upcoming budget request. Information about the upcoming retreat can be found on the OHCA website in July.

Medical Advisory Committee (MAC). The MAC is comprised of medical professionals and consumer organizations who meet bi-monthly to discuss the interests and needs of the SoonerCare population. The committee reviews and advises the agency on best practices and medical policies and procedures. The meetings are open to the public and are often attended by providers and advocacy groups who actively participate. Meeting dates are



OHCA hopes this report will give you the right information to evaluate our performance. Let us know if we succeeded. If we did not, then we need your help! Please let us know what would make it better. Call or send your input to:



Performance & Reporting
405.522.7917, Paul.Gibson@okhca.org

posted on the agency's public website at [www.okhca.org/about us/Medical Advisory Committee](http://www.okhca.org/about-us/Medical-Advisory-Committee).

Drug Utilization Review (DUR). The DUR board is comprised of medical professionals with expertise in pharmaceuticals. The board meets monthly and advises OHCA on appropriate use and best practices related to medications. The DUR reviews such topics as drug therapies, and formularies, and also reviews public requests related to medication.

These meetings are open to the public and are often attended by providers, pharmacy organizations, and consumer advocacy groups who actively participate in the meetings. Meeting dates are posted on the agency's public website at [www.okhca.org/about us/Drug Utilization Review Board](http://www.okhca.org/about-us/Drug-Utilization-Review-Board).



Advisory Committees and Task Forces. In addition to public meetings, the agency has several task forces and committees in which the public advises the agency on targeted topics. More information on the following groups can be found on OHCA's website at [www.okhca.org/about us/boards and committees](http://www.okhca.org/about-us/boards-and-committees).

Child Health Advisory Task Force. OHCA, in collaboration with the Oklahoma State Department of Health (OSDH), established a Child Health Advisory Task Force to assist both agencies in developing improved benefits and services for Oklahoma's low income families. This ongoing committee advises OHCA and OSDH on children's health issues such as how to improve the quality/quantity of child health screenings and follow-up care, and how to identify better ways to address wide-spread children's health problems throughout the state. Information about the Child Health Advisory Task Force can be found at [www.okhca.org/about us/Child Health Advisory Task Force](http://www.okhca.org/about-us/Child-Health-Advisory-Task-Force).

Perinatal Task Force. This task force is composed of more than 20 agencies and organizations involved with perinatal care. It was developed to focus on issues concerning pregnant women covered by SoonerCare or other public health sources. The task force provides expertise regarding perinatal health care and makes recommendations regarding systemic modifications that may contribute to improving perinatal outcomes in Oklahoma. Information about the Perinatal Task Force can be found at [www.okhca.org/about us/Perinatal Task Force](http://www.okhca.org/about-us/Perinatal-Task-Force).

Living Choice Advisory Committee. This committee advises and assists OHCA and its partner agencies in the design, development, and implementation of the Living Choice program. The program serves nursing home level of care members in the community and the committee provides the consumer and family perspective. Along with representatives from the participating agencies and non-profit groups, membership includes persons of all ages with disabilities or long-term illnesses, and family members or advocacy groups representing them. Information about the Living Choice Advisory Committee can be found at [www.okhca.org/about us/Living Choice Advisory Committee](http://www.okhca.org/about-us/Living-Choice-Advisory-Committee).

DME Advisory Council. This new council began in January 2010 and provides input on OHCA policy and specific issues related to Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS). Members on the council include DME providers and stakeholders representing DME organizations. The council has been instrumental in making coverage and pricing suggestions during the budget crisis. More information is available at [www.okhca.org/providers/DME Advisory Council](http://www.okhca.org/providers/DME_Advisory_Council).

Focus on Excellence Advisory Committee. Established in the fall of 2010, this committee advises OHCA on the Medically Fragile, My Life: My Choice, and Sooner Seniors Waiver. This committee meets monthly.

Dental Workgroup. The Dental Workgroup was established in 2010 with the objective of developing ways to establish a SoonerCare oral health care standard. This workgroup is designed to be a time limited task force and will meet eight times per year.

Behavioral Health Advisory Council. This council was established in 1999 and meets quarterly. The aim of this council is to facilitate communication between OHCA consumers, providers and other stakeholders. The mission of the Council is to provide input to the OHCA and designated agents regarding behavioral health care within Oklahoma's Medicaid programs. The Council hopes to foster communication, understanding and participation from the stakeholders and to recommend policy changes to OHCA leadership. In order to facilitate participation and recommendations, the OHCA staff and designated agents will provide education, and information regarding the current Oklahoma Medicaid program, federal policy and other issues relevant to quality service improvement.

Medical Advisory Task Force. The purpose of this task force is to be a direct line of communication between OHCA and the practicing physician. The task force hopes review and advise physicians on OHCA programs and policy. The task force was formed in 2006 and meets monthly.

Member Advisory Task Force. This new task force was established in 2011 and meets every other month. The purpose of this task force is to improve the SoonerCare choice program by receiving input and feedback from members and their families.

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GOAL # 1: ELIGIBILITY

<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
Outcome - % of Oklahomans Enrolled in Medicaid	20.74%	21.1%	21.91%
Output - Unduplicated Medicaid Enrollment - Total	742,152	763,565	797,556
Outcome - % of Enrollment Change (includes Insure Oklahoma)	6.5%	2.9%	4.5%
Online Enrollment Applications (at home or partner agency)	Not Available	Not Available	Not Available
Insure Oklahoma –Employee Sponsored Enrollment	Not Available	Not Available	Not Available
Insure Oklahoma –Individual Plan Enrollment	Not Available	Not Available	Not Available

OKLAHOMA HEALTH CARE AUTHORITY

TO PROVIDE AND IMPROVE HEALTH CARE ACCESS TO THE
UNDERSERVED AND VULNERABLE POPULATIONS OF OKLAHOMA.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
22.38%	23.6%	25.61%	26.60%	27.63%
825,138	885,238	968,296	1,016,711	1,067,571
3.5%	7.3%	9.4%	5.0%	5.0%
Not Available	Not Available	60%	60%	60%
14,217	18,753	18,816	18,740	19,101
7,381	13,107	13,784	13,648	13,922



GOAL # 2: QUALITY AND SATISFACTION

<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
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<i>Customer Survey Results (CAHPS®)*</i>	<i>ADULT</i>	<i>CHILD</i>	<i>ADULT</i>
<i>Outcome - Rating of Health Plan</i>	65.5%	72.3%	62.1%
<i>Outcome - Rating of Health Care</i>	68.7%	74.2%	60.6%
<i>Outcome - Rating of Personal Doctor</i>	77.0%	75.1%	65.1%
<i>Outcome - Rating of Specialist</i>	72.8%	76.1%	68.8%
<i>Outcome - Customer Service</i>	82.6%	72.1%	78.1%
<i>Outcome - Courteous / Helpful Office Staff</i>	82.0%	89.2%	83.1%
<i>Outcome - How Well Doctors Communicate</i>	79.6%	88.7%	80.4%
<i>Outcome - Getting Care Quickly</i>	64.9%	74.8%	77.1%
<i>Outcome - Getting Needed Care</i>	80.1%	78.4%	72.8%

Focus on Excellence

<i>Percent of 5 star facilities</i>	Not Available	Not Available	7.5%
<i>Percent of 4 star facilities</i>	Not Available	Not Available	20%
<i>Resident Satisfaction Survey</i>	Not Available	Not Available	Not Available
<i>Employee Satisfaction Survey</i>	Not Available	Not Available	Not Available

OKLAHOMA HEALTH CARE AUTHORITY

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY WITH PROGRAMS, SERVICES, AND CARE.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
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CHILD	ADULT	CHILD		
82.3%	64.3%	78.4%		Not Available
74.5%	61.6%	78.1%		Not Available
80.3%	71.8%	82.2%		Not Available
75.0%	74.9%	84.7%		Not Available
75.3%	78.2%	80.1%		Not Available
Not Reported	Not Reported	Not Reported		Not Available
88.8%	84.2%	91.6%		Not Available
87.6%	81.8%	87.1%		Not Available
76.8%	77.8%	80.0%		Not Available

8.2%	6.3%	5.7%	Not Available	Not Available
21.2%	20.4%	21.3%	Not Available	Not Available
74%	92%	Not Available	Not Available	Not Available
67%	79%	Not Available	Not Available	Not Available



GOAL # 3: MEMBER PERSONAL RESPONSIBILITY

<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
<i>% of Children Accessing Well-Child Visits/EPSTD</i>			
<i>First 15 months</i>	96.5%	96.8%	97.3%
<i>3 to 6 years</i>	56.7%	57.1%	60.0%
<i>Adolescents</i>	25.9%	28.6%	32.1%
<i>Outcome - immunization rate</i>			
	77.6%	53.3%	56.4%
<i>Adults Health Care Use - Preventive / Ambulatory Care</i>			
<i>20 to 44 years</i>	74.9%	75.6%	78.4%
<i>45 to 64 years</i>	84.2%	85.2%	86.8%
<i>ER Visits per 1,000 Visits</i>			
<i>TANF</i>	70	70	72
<i>ABD</i>	47	48	50
<i>Total Population</i>	63	64	66
<i>EPSTD Screening Ratio</i>			
	NA	70%	73%
<i>Average # of Members in Pharmacy Lock-In</i>			
	212	199	145
<i>% of Members Seeking Prenatal Care</i>			
<i># of Births</i>	27,027	32,303	32,438
<i>First trimester</i>	56%	43%	44%
<i>Second trimester</i>	25%	35%	34%
<i>Third trimester</i>	10%	16%	16%

TO PROMOTE MEMBERS' PERSONAL RESPONSIBILITIES FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
97.4%	98.3%		Not Available	
64.9%	59.8%		Not Available	
40.1%	33.5%		Not Available	
61.0%	61.6%		80% (Target)	
83.3%	84.2%		Not Available	
89.7%	91.1%		Not Available	
70	51	48	Not Available	
51	45	47	Not Available	
64	49	47	Not Available	
83%	77%	NA	Not Available	
165	268	303	Not Available	
97%	96%	98%	90% (Target)	
33,228	33,669	32,060	Not Available	
46%	54%	57%	90% (Target)	
36%	29%	29%	Not Available	
15%	13%	12%	Not Available	

GOAL # 4: MEMBER BENEFITS



<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
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<i>Medical Home</i>			
<i>Number of SoonerCare Members Enrolled in Medical home</i>	Not Available	Not Available	Not Available
<i>Number of SoonerCare Traditional Members</i>	Not Available	Not Available	Not Available
<i>Percent of SoonerCare Members Enrolled in Medical Home</i>	Not Available	Not Available	Not Available

<i>Provider Capacity**</i>			
<i>SoonerCare Choice PCP Total Capacity</i>	Not Available	Not Available	1,362,570
<i>SoonerCare Choice PCP Percent of Capacity Used</i>	Not Available	Not Available	33.26%
<i>Total Unduplicated Provider Count</i>	Not Available	Not Available	25,127

<i>Outcome - % of SoonerCare Members filing appeals</i>	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%
<i>Output - # of SoonerCare Member Appeals Filed</i>	42	45	46
<i>Output - % of OHCA Decisions Overturned</i>	10%	7%	4%

**During implementation of Medical Home, providers renewed their contracts with OHCA. Part of the renewal process included a self-assessment that requested updated Medical Home Panel capacity and the number of hours the provider is available for appointments. OHCA staff set Panel capacity maximum limits based on available hours reported. Medical Home primary care providers can now go online and adjust their capacity at any time.

OKLAHOMA HEALTH CARE AUTHORITY

TO ENSURE THAT PROGRAMS AND SERVICES RESPOND TO THE NEEDS OF MEMBERS BY PROVIDING NECESSARY MEDICAL BENEFITS TO OUR MEMBERS.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
400,642	434,969	425,246	446,508	Not Available
213,073	220,283	245,159	257,417	Not Available
64%	67%	64%	64%	Not Available
1,829,549	1,037,499	1,071,965	1,201,483	1,204,472
21.90%	41.30%	39.55	38.42%	39.76%
28,446	28,637	30,113	40,170	43,807
<1/4 of 1%	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%	<1/4 of 1%
56	158	61	<75	<75
7%	6%	13%	<20%	<20%



GOAL # 5: RESPONSIBLE FINANCING /
PURCHASING

<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
<i>Input - Cost of Physicians & Other Providers</i>	\$467,799,496	\$526,971,220	\$584,390,421
<i>State Employed</i>	140%	140%	140%
<i>Non-State Employed</i>	99.99%	99.99%	100%
<i>Input - Cost of Hospital Services</i>	\$681,308,932	\$811,684,896	\$835,440,046
<i>Outcome - Hospital Reimbursement as % of "Costs"</i>	80%	102.7%	102.5%
<i>Input - Cost of Nursing Facilities & ICF/MR</i>	\$486,701,460	\$544,216,963	\$572,973,234
<i>Outcome - Nursing Facility Rates as % of Cost</i>	89.8%	95%	96.2%
<i>Outcome - ICF/MR Rates as % of Cost</i>	97.1%	101%	103.7%
Cost of EHR Payments to Eligible Professionals	Not Applicable	Not Applicable	Not Applicable
Cost of EHR Payments to Hospitals	Not Applicable	Not Applicable	Not Applicable
Number of Eligible Professionals Receiving EHR Payments	Not Applicable	Not Applicable	Not Applicable
Number of Hospitals Receiving EHR Payments	Not Applicable	Not Applicable	Not Applicable

OKLAHOMA HEALTH CARE AUTHORITY

TO PURCHASE THE BEST VALUE HEALTH CARE FOR MEMBERS BY PAYING APPROPRIATE RATES AND EXPLORING ALL AVAILABLE VALID OPTIONS FOR PROGRAM FINANCING TO ENSURE ACCESS TO MEDICAL SERVICES BY OUR MEMBERS.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
\$646,348,284	\$844,813,899	\$893,069,345	\$828,902,342	\$909,782,021
140%	140%	140%	140%	140%
100%	99.19%	96.75%	95.75%	96.75%
\$862,201,042	\$927,614,585	\$906,160,879	\$934,025,971	\$1,003,801,893
99.66%	101%	95%	124%	100%
\$574,114,181	\$570,884,055	\$544,321,297	\$531,935,402	\$621,534,452
97.5%	94.5%	89.2%	100%	100%
100.6%	100.3%	100.6%	100%	100%
Not Applicable	Not Applicable	\$12,572,917	Not Available	Not Available
Not Applicable	Not Applicable	\$22,698,793	Not Available	Not Available
Not Applicable	Not Applicable	592	Not Available	Not Available
Not Applicable	Not Applicable	33	Not Available	Not Available

GOAL # 6: ADMINISTRATION



<i>Performance Measure</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>
Outcome - % of Administration Dollars Used	NA	NA	80.2%

Total SoonerCare Administration Costs	NA	NA	\$87,000,000
Total Contract Cost (Component of Administration Costs)	NA	NA	\$51,500,000
% of Administration Costs Attributed to Contracts	NA	NA	59%
Average SoonerCare Program Cost per member	NA	NA	\$4,816
Average Cost Per Insure Oklahoma Member	NA	NA	\$2,791

Total Claims Paid	23,621,535	23,332,124	25,309,251
Payment Accuracy Rate	93%	91%	99%

<i>Payment Integrity Recoveries</i>	\$8,969,963	\$9,261,371	\$6,394,754
<i>Third Party Liability Recoveries</i>	\$14,135,694	\$12,517,646	\$13,068,272

Provider Training			
<i>Group Training-Seminars/Workshops/Bi-Annual</i>	155	100	85
<i>Group Training-Attendees</i>	7,282	7,215	8,590
<i>Individual - On-Site Trainings</i>	4,684	5,112	3,961
<i>Total Member and Provider Calls</i>	286,531	334,016	375,575

Involuntary Terminations of Provider Contracts	25	34	22
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OKLAHOMA HEALTH CARE AUTHORITY

TO FOSTER EXCELLENCE IN THE DESIGN AND ADMINISTRATION OF THE SOONERCARE PROGRAM.

<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012 (Est.)</i>	<i>2013 (Est.)</i>
90.7%	82.1%	89.5%	100%	100%

\$97,300,000	\$119,200,000	\$134,200,000	\$168,000,000	NA
\$59,800,000	\$83,300,000	\$94,800,000	120,000,000	NA
61%	70%	71%	71%	NA
\$4,892	\$4,911	\$4,712	\$4,806	\$4,902
\$3,140	\$3,399	\$3,530	\$3,664	NA

28,428,254	31,691,202	34,823,106	>45,000,000	>45,000,000
99%	98%	>97%	>97%	>97%

\$3,988,042	\$17,614,428	\$9,077,565	\$4,500,000	\$4,500,000
\$24,910,078	\$41,521,418	\$43,241,434	\$35,000,000	\$35,000,000

149	185	117	NA	NA
9,584	11,739	11,672	NA	NA
4,172	4,043	6,644	NA	NA
415,157	423,547	515,935	>530,000	NA

36	47	36	<55	<55
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